Provincial
Health Council

HEALTH for Nova Scotians

The results of a public consultation process

June 2000

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28 June 2000

The Honourable John F. Hamm
Premier of Nova Scotia
P.O. Box 726
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The Honourable Jamie Muir
Minister of Health
P.O. Box 488
Halifax, Nova Scotia

Dear Sirs:

It is our pleasure to present, on behalf of the Nova Scotia Provincial Health Council, the attached document entitled "HEALTH IN NOVA SCOTIA: The Results of a Public Consultation Process".

This document contains the results of the public consultation carried out by the Council earlier this year. It also contains an initial group of recommendations formulated by the Provincial Health Council following the consultation with Nova Scotians and with the advice of an Advisory Committee struck for this purpose.

We submit this document and its recommendations in the sincere hope that its production will assist the Government of Nova Scotia to help all government departments examine the impact of their actions on the health of Nova Scotians. We also hope it will encourage the Department of Health to develop a health care system that is based on the determinants of health, the Health Goals of Nova Scotia, and the vision of a health care system as described by Nova Scotians.

We would like the opportunity to present a summary of our findings to the Cabinet of Nova Scotia and would also like to participate with you in a joint press release and the release of the document to the public.

Sincerely,

Barbara Hart
Barbara Hart
Chair

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> **All the Community Health Board members and other individuals that helped the Council organize and host meetings, and distribute workbooks;**
>
> **The Advisory Committee created to help the Council with this process; and**
>
> **The individual Nova Scotians who:**
>
> - **filled in the workbooks**
> - **attended the public meetings**
> - **wrote and presented submissions**
> - **answered questions on the 1-800 number**

Table of Contents

Letter of Transmittal

Provincial Health Council Members i

Acknowledgements ii

Table of Contents iii

List of Appendices iv

Executive Summary v

Recommendations vii

Nova Scotian's vision for health x

Nova Scotia's Health Goals, public comment xi

Introduction

Approach of Council 1
The Process 2

Key Input to our Understanding of Core Services

Community Health Plans 3
Workbooks 10
Public Meetings 27

Summary of Findings: Major Themes

Access 36
Health promotion / Disease Prevention / Education 37
Clean Environment 38
Services for Seniors 38
Services for Youth 38
Mental Health Services 38
Community Based Planning & Delivery 38

References Consulted 39

Appendices 46

List of Appendices

1.0 Planning
    1.1 Minutes
    1.2 Background Statistics
    1.3 Canadian Summary
    1.4 NS Department of Health Material
    1.5 Nova Scotia Health Goals & The Determinants of Health

2.0 Advisory Committee
    2.1 Pre-meeting questionnaire
    2.2 Summary of participant responses to questionnaires
    2.3 Participant list
    2.4 Summary of meetings
    2.5 Evaluation tool
    2.6 Evaluation of session

3.0 Workbooks
    3.1 English
    3.2 French

4.0 Public Consultations
    4.1 List of meetings
    4.2 Facilitator's guide
    4.3 Meeting transcripts

5.0 Community Health Plans Summary

6.0 Respondent Profile

7.0 The Core Clinical Services Report March 2000
    ("ESSENTIAL HEALTH SERVICES: A Preliminary Report to the Minister of Health Containing a list of Core Clinical Services Nova Scotians Consider Essential to their Health.")

Executive Summary

The Provincial Health Council was mandated by the Government of Nova Scotia to develop a list of core clinical services to be provided at the community, regional and provincial levels in Nova Scotia. This list was to be developed through public consultation.

The Provincial Health Council was re-instated in October 1998 after a hiatus of 3 years. The Council decided to use the government mandate as a platform to begin dialogue with Nova Scotians about the Health Council, the determinants of health, the Health Goals of Nova Scotia and about core clinical services.

The Council used three methods to obtain public input into the core services list: the Community Health Plans created by the Community Health Boards across the province; a workbook created and circulated to approximately 11,000 people; and public meetings across the province.

This latter venue was also used to re-introduce the Council to Nova Scotians, and to begin the dialogue around determinants of health and the Health Goals of Nova Scotia.

During our discussions with Nova Scotians we heard many things about health and health care in this province. A very small part of this information went to make up the list of core clinical services requested by the government. The list was created and submitted to the Department of Health in March of 2000. A copy of this list is included in Appendix 7. Much of the rest of the information obtained is neither new, nor revolutionary. Nova Scotians told us the same things they have been saying about health care and the system for the past 28 years, with one major addition. Overwhelmingly, Nova Scotians told us to stop asking them the same questions over and over again and get on with creating a health care system to meet the needs of Nova Scotians now and for the next thirty years.

Nova Scotians told us their vision of a health care system. It is a system that is accessible, equitable, affordable, community based and aimed at health promotion and illness prevention.

Nova Scotians talked to us about health and health care, delineated not on the disease based format providers use, but structured around services delivered to different populations such as youth, new families, and seniors.

Nova Scotians are concerned about the determinants of health and the effects on their health status. We heard much about the lack of clean air and clean water; the effects of poverty on various parts of our province; the levels of illiteracy in Nova Scotia; the inadequate sewage and garbage disposal; the effects of the destruction of our social and family support systems; and the extreme difficulties generated by lack of employment opportunities in many parts of the province.

Transportation was mentioned often enough to merit a discussion on its own. Lack of an adequate public transportation system for the province creates an inequity in access to not only health care, but also to cultural events, social events and individual participation at even the community level of decision making.

Nova Scotians also discussed system issues such as human resource management, the need for integration of the system to provide a seamless (from the consumer viewpoint) continuum, the need for the providers and the system to become accountable for decisions made, the need to re-orient our delivery to emphasize health promotion and illness prevention, and especially the need for Nova Scotians to become individually responsible for their own health.

In the body of the report you will find analyses of approximately 1,100 workbooks, 31 public meetings comprising input from approximately 1,100 people, 24 Community Health Plans, and the results of the deliberations of the Advisory Committee. The identified themes were similar across all of these sources of information. You will also find recommendations to government related to many aspects of healthy public policy, formulated around the Health Goals of Nova Scotia and the determinants of health.

In summary, the Provincial Health Council is confident that this report accurately reflects the opinions of Nova Scotians about health and the health care system, and contains recommendations that will lead to improvement of the health care system, integration of various government departments delivering services that affect the health of Nova Scotians, and a consequent improvement in the health status of Nova Scotians.

Recommendations

Preamble

The following are the recommendations of the Provincial Health Council. These recommendations are based on input from Nova Scotians obtained through the 24 Community Health Plans, a series of 32 public meetings, the workbooks completed by 1100 Nova Scotians; and the work of the Advisory Committee (Participant List in Appendix 2.3) in interpreting the findings and making suggestions. The Council, in formulating its recommendations, identified key findings in all the sources of input. The recommendations are not in any particular order of priority. No attempt has been made in this document to make recommendations at a micro level of management.

Recommendation # 1

That government provide a leadership role that will encourage those who influence health to challenge the traditional definition of health and move towards a definition that is based on the broad determinants of health, Nova Scotian's vision of health, and the Health Goals of Nova Scotia.

Recommendation # 2

That all elected and appointed officials of the Province of Nova Scotia, and all staff of government departments, commit themselves to Nova Scotians' vision for health as expressed in public consultation and in the Nova Scotia Health Goals and work towards healthy public policy integrated across government lines. This includes ensuring that policies:

- address the Health Goals,
- set specific targets to reach Health Goals, and further,
- set evaluation processes to check on progress towards the Health Goals.

Recommendation #3

That government encourage all relevant agencies and persons take available opportunities to communicate Nova Scotians' vision of health and the Nova Scotia Health Goals.

Recommendation # 4

That government provide tools and services to Nova Scotians that encourage people to take responsibility for their own health and that support them in this effort.
Examples could include:

- educational programmes on:
  - healthy living,
  - how to manage a variety of health challenges,
  - how to access health services that are most appropriate for the situation.
- readily available community internet access.

Recommendation # 5

That government develop and commit to a long term plan to ensure stability, continuity, and sustainability of health related services, such plan to include:

- Mechanisms to ensure that the vision identified by Nova Scotians is operationalized.
- Mechanisms to ensure that all Nova Scotians including First Nations people are fully considered in the plan, especially examining jurisdiction and access to services.
- A strong human resources plan to ensure the appropriate mix of health service professionals based on identified client and community needs.
- Mechanisms to ensure that changes to the health services delivery system be reasoned and evidence based.
- Mechanisms to ensure accountability and regular evaluation of the impact of policies and activities on health status through the appropriate government departments.

Recommendation # 6

That the government plan and implement programmes and services

- based on the needs of communities related to health,
- involving communities in decisions affecting their health, and
- that people can access, wherever possible, through their home community.

Recommendation # 7

That all services be provided with consideration of values, culture, language, religion, ethnicity and individual ability, and that all people be treated at all times with respect and dignity.

Recommendation # 8

That government establish information policies and systems to support an integrated, coordinated continuum of services, to include:

- making sure that client and other information can move quickly and easily across location, government and provider lines, where needed for continuity of care and services,
- developing an electronic health record that is built around health outcomes,
- gathering data that supports research into the long-term impact of health service delivery activities or other policies and changes on health outcomes.

Recommendation # 9

That government ensure that the District Health Authorities provide the Community Health Boards and community organisations with tools and advice on how to complete a community health profile and assessment.

Recommendation # 10

That government provide appropriate resources and recognition for volunteers to work effectively within their communities.

Recommendation # 11

That government enhance public policy and action around provision of public transportation that will support access to health services and opportunities for healthy living for all Nova Scotians.

Recommendation # 12

That the Provincial Health Council ensure that a regular report on health for Nova Scotia be developed. The report would outline the results of monitoring and evaluation of:

- the efficacy, effectiveness and efficiency of the present system in maintaining or improving health status of Nova Scotians
- the implementation of an acceptable health plan, and
- the impact of policies and system changes on the health status of Nova Scotians.

A Vision for Health for Nova Scotia

Nova Scotians see health, for themselves and for others in the province, that is based on:

- Processes and services that are **community centred.**
- Processes and services that are **efficient, affordable and sustainable.**
- All Nova Scotians being treated equitably and having **equitable access** to health services.
- A reorientation of focus towards **education for healthy living, health promotion and illness/injury prevention.**
- Services and processes that are **integrated and coordinated** across lines of government, providers and communities.

Nova Scotians have stated that, to accomplish this, we have to work with:

- A vision for health (as described above).
- A long-range plan (10 years) to work on all aspects of the vision.
- Coordinated implementation of the plan.
- Research and evaluation of the impact of activities based on information on outcomes, especially in terms of health status improvement.
- Holistic service delivery that addresses the needs of a whole person within their own context. This means an emphasis on seniors/elderly rather than "geriatrics", services for youth, rather than "paediatrics", as examples.

Nova Scotia's Health Goals

The results of our public consultation have shown that Nova Scotians want exactly those things expressed in the document entitled "Nova Scotia's Health Goals" which has recently been re-affirmed by government. Following each of the Nova Scotia Health Goals is a series of comments from a variety of Nova Scotians. These comments are from several sources, including the public meetings, the workbooks, the Community Health Plans and the Advisory Committee.

Health Promotion: Promote and improve the health of all Nova Scotians. ***While continuing to provide quality health care, we will shift our emphasis to the promotion of health and the prevention of illness, disability and premature death.***

That we challenge traditional definitions of health, which are primarily focused on the absence of illness or injury; and move towards a definition of health that is based on the broad determinants of health and that supports people living and working in their communities.

Less technology and more promotion and prevention

The government needs to hear that we want to, live in communities that promote our health, and for the government to put money that would recognize the shift

emphasis should be on health education and health promotion and redirected from existing systems

The health system needs to be balanced: helping to improve and maintain health, as well as looking after me when I'm sick

Core in the school system should be health education and illness prevention so we don't have to start teaching it to adults

Healthy Environment: Make Nova Scotia a safe and healthy place to live. ***To be healthy, we need clean air, water, and soil, as well as safe places to live, work, and play. We will restore, protect, and develop our environments to support health.***

Caring for the environment includes having clean air to breathe (including in buildings); being smoke free and scent free. We also need to regulate toxins and clean up polluted areas and toxic waste sites (e.g. tar ponds, Halifax and Sydney harbours)

Example of respect for the environment that incorporates the whole medicine wheel: creation of the medicine trail by the medicine trail committee – in its creation the *environment was respected in all ways, it gives people a chance to work with herbal medicines growing along the trail, it provides physical recreation and a chance to get in touch with the spiritual*

Sydney sewer will be dumped directly into the harbour shortly untreated, 26 lines currently dumping into the tar ponds will be re-routed to Sydney Harbour, this needs to be addressed immediately

TriHaloMethane in the water, from organic matter in the water interacting with the chlorine in the water ... Ozoning the water is more efficient ... The provincial government need to tell the municipal government that water is important

Need to ensure that all Nova Scotians have healthy soil and healthy water

Living in a half-decent place with enough to eat, heat and light

Healthy Living: Support the efforts of individuals, families and communities to lead healthy lives. ***We will support each other in our efforts to understand the factors that affect our health and take responsibility for those things we can control.***

- *There is inadequate attention to the broadest health determinants.*
- *We need mechanisms to implement the Community Health Plans (which are focused on community-based health and healthy living).*
- *We also need tools to allow individuals to take individual responsibility for health and community responsibility/authority for resources for healthy living.*

Less than 4% goes into health promotion. We well know that nutrition, clean water, etc., is good stuff, we don't have many incentives, or things that are accessible to many people for lifestyle choices, costs money to exercise, need people trained, in larger numbers, having free clinics for people to come and get counseling on diet, exercise, etc.

Need to look at a holistic approach rather than the present medical model

Management: Ensure that the resources needed to support health are managed wisely and fairly. ***Our taxes pay for the people, programmes, equipment, and facilities that support health. These and other resources will be used in ways that are open, effective, efficient, and accountable.***

- *Better management of existing resources*
- *CHBs need connections beyond those health care providers have traditionally used.*
- *Provide communities (through CHBs or DHAs with tools, advice, authority and dollars needed to address the community's health needs.*
- *There are gaps/duplication/complexity of services and changes.*

- *Understanding and information on outcomes (and their relationship to activities) needed. Put value on what works.*
- *Resource allocation according to priorities needed.*

There is no transition from the hospital to the community, there is no opportunity to integrate into the community from the hospital

Message to government, look at a process of health impact assessment build on the determinants, look at the examples from this region

Please stop the chaos - to get our house back in order, need a long-term plan that is not dependent on every political whim and is based on a long-term fiscal plan

Governments need to develop a long-term, multi-faceted approach to health (all government needs to be involved). Need a plan that's not going to change after each election - because of this lack of direction, volunteers are feeling burned out by the process and need to be nurtured

Also need to bring the different people from different government departments together to work on all facets of health, what kinds of choices do you have to make and on what values

Participation: Involve Nova Scotians in decisions affecting health.

Opportunities and support must be provided for all of us to participate in making decisions about our health and the health care system. All decision makers are accountable to the public for their actions.

Good news! People know what they need – now we have to do it!

Overwhelmingly, respondents said that the best way to ensure their participation in health related decisions is to listen to what they are saying. Respondents indicated they are tired of being asked the same questions over and over again; and they are very skeptical that anything will come of their comments and suggestions.

Don't change horses with each government

There needs to be commitment from the people who make decisions to support these initiatives in the community

Development comes from the inside out, not the outside in

In the future make sure youth are involved in the decision making process, make sure the youth voices are heard

Need to feel that when we make submissions someone listens. It's hard to feel healthy when you feel helpless

Communities can be very resourceful, can plan programmes and services to meet the needs of the residents, they can often do it with a bit of seed money, government should support and nurture communities that are trying to do their own thing, help the communities to build on what they are trying to do in their own communities

Social Justice: Insure that all Nova Scotians have the opportunity to achieve health. ***Poverty, unemployment, racism, illiteracy, violence, rural isolation and other issues make it more difficult for some people to be as healthy as others. The policies we put in place must address these factors that affect our health.***

Equal access to all areas of health. Reliable information. Nova Scotians have the right to good health but also a responsibility to look after their own health.

concern that programs that are for "all Nova Scotians" are not for the Mi'kmaq who live on the reserves, that "we are Mi'kmaq in Nova Scotia, not of Nova Scotia.

Healthy public policy – an approach that looks out for how any policy or change will impact on the health of the citizens

Our system must create a forum that will allow the silent voices to be heard, the ones that are ignored

The rural area heart attacks are just as important as those in Halifax

Introduction

In July of 1999, the Provincial Health Council received a request from the Premier to enter into a consultation process with Nova Scotians to find out what clinical services they felt were needed at the community, district or region, and provincial levels. This report outlines how the Council approached the task, the methods used to consult with Nova Scotians in a meaningful way and the results of that consultation in relation to clinical services.

Approach of Council

The Council, since its current form came into being, has adopted an approach to all issues related to health for Nova Scotians that focuses on the broad determinants of health and the Nova Scotia Health Goals which have been adopted by the current government. These are described in Appendix 1.5. What this has meant for the current process is that we looked more broadly than "core clinical services" and dealt with "core health services" throughout. Core clinical services becomes a sub-set of core health services in this approach.

We also used this as an opportunity to get in direct contact with Nova Scotians: to put a face to council and to begin a dialog with them in relation to health and health issues.

The Process

The Council began by appointing a Core Services Advisory Committee to help shape the questions to put to Nova Scotians in our direct consultation, and to begin the process of identifying the core services needed at the three levels. This committee comprises approximately 50 people with representation from Community Health Boards; the former Regional Health Boards; the non-designated facilities; related professional organisations including the Registered Nurses Association of Nova Scotia and the Medical Society; the Departments of Health, Community Services, Environment, Education and Justice; the Sport and Recreation Commission; several non-governmental organisations (primarily health-related charities); and persons who represented special interests or minority communities which were deemed important.

Additional steps included:

- Preparation of background information relating to core services identified by the NS Department of Health, other provinces, some jurisdictions in the USA, some in Europe, the World Health Organisation and others. We also prepared some statistical information related to population health for Nova Scotia as a whole and for each county. This material was distributed to the Advisory Committee to be used as a background for their work.

- A two-day meeting of the Advisory Committee to begin the process

- Development and distribution of questionnaires in the form of workbooks. Eleven thousand (11,000) of these were printed: 10,000 in English and 1000 in French; and distributed through a number of avenues including the Community Health Boards and other interested groups in a community. Approximately 1100 of these had been returned by the end of April. The quantitative data in nine hundred and eighty (980) were analysed by the consulting evaluation research company. The qualitative data in 300 were analysed by the research company and in the remaining 800 by the council members and staff.

- Consultation with the public through a series of public meetings. Thirty-two (32) of these were held across the province including 3 in First Nations communities. The format of these meetings was originally planned to be workshop/focus group, but the large numbers at many of the meetings made this impossible except for 6 meetings. Approximately 1100 persons attended these but there was wide variation in the numbers at any one location. Attendance ranged from 360 (Kentville) to 1 (Spryfield).

- Analysis of the workbooks and the reports from public meetings by a consulting firm specialising in evaluation research. This analysis was both qualitative and quantitative.

- Review of all of the Community Health Plans available to date from the Community Health Boards. Various people told us that each CHB had done an extensive assessment of needs in the communities using a variety of assessment processes and that this would provide very valuable information based on more than just a one-time meeting. The review was done for the purpose of identifying the core services noted in the plans. It must be noted that the services taken from the plans were those that the community planned to work on over the coming year(s), and was not an exhaustive list of core services needed on an on-going basis (only on those that were considered deficient or lacking and needed work).

- Preparation of an interim report on core clinical services. In March of 2000, the Provincial Health Council presented a preliminary report on core clinical services as requested by the Department of Health. The information contained in this report was taken from the same sources as those used for this report, but was focused only on the input people gave on the clinical services. This input expressed a need for various clinical services at each of the three levels of community, district or region and one place only in the province. The Department of Health used this as a significant part of the input for the Clinical Footprint Committee, which is currently preparing a framework for the clinical services provided in districts across the province.

Key Input to Our Understanding of Core Services

There were three primary sources for input into our understanding of the core health services that Nova Scotians expect:

- The Community Health Plans developed across the province by the active Community Health Boards
- Workbooks on core health services, including core clinical services, completed by more than 1100 people from across Nova Scotia.
- Public meetings held across the province with a variety of communities (at least one in each county), including several First Nations communities, and attended by over 1100 people.

The following elements of the report give a summary of the findings from each of these sources. This is followed by a summary of the key findings across these elements:

Community Health Plans

The following is a summary of the issues presented by the community health boards (CHBs) in Nova Scotia as presented in their Community Health Plans. Twenty-two of the CHBs presented plans to their respective regional health boards (RHB's) between 1997 and 1999. All of the plans were reviewed to determine which issues were priorities for the community health boards and if there were any common themes presented across the province. The issues summarized in the initial portion of this document are the issues which most (i.e. more than half and up to all) of the community health boards indicated as significant issues for their communities. Prioritizing these issues was not possible as the methodologies used by each of the boards to select issues for discussion varied.

It is also important to note that the Community Health Plans were composed for maintaining, improving and adding services, not for giving an exhaustive list of what was needed in each community. We have to look to other sources for finding the totality of needs for the community; this process only identifies the unmet needs that the CHB planned for over the short term.

Methodologies

Each of the community health boards used a variety of methods to collect relevant information for their health plans. Some of the most common methodologies included but were not limited to: focus groups, public meetings, surveys, needs assessments, presentations by community groups, service inventory, CHB meeting discussions, and written submissions. Information for the community health profiles was gleaned from Statistics Canada publications, needs assessments etc. Once the information was gathered, some of the boards used it to prioritize their health issues. If a method of prioritisation was used, the CHBs prioritized the issues that were listed or mentioned the most frequently in the information gathered. However, most community health plans did not indicate how or if the issues were presented according to priority. In order to select issues for this discussion, the most frequently mentioned issues and themes are presented first and then some issues that were indicated to be of unique importance to particular CHBs are presented.

Limits

All of the health boards made some mention of the difficulties and limitations faced in developing their community health plans. Some of the limits included but are not limited to:

- Lack of community awareness regarding the role and function of the CHB
- Many of the CHBs felt they had insufficient time to complete the plans. As a result the plan is in draft form and may evolve as more issues and information are uncovered.
- There were difficulties in data collection. Some CHBs had to rely on data from 1991 from Statistics Canada, as they were unable to access data from the most recent census. Others mentioned that different organisations collect data on utilization rates cost etc, differently, therefore making it difficult to compare organisations. Also the Statistics Canada information often did not coincide with the community health board boundaries and the boards were forced to rely on census division data or data for the province as a whole to make assumptions regarding their particular populations.
- Since this is the first time CHB plans were created in Nova Scotia, the boards cited a lack of a model or template as a difficulty in developing the plan.
- Some boards felt that they did not receive enough information from the community.
- Many of the boards mentioned low response rates to request for submissions, surveys, community meetings, etc and as a result they had to rely on data generated from a small sample size.
- The knowledge and resource level of board members varied throughout the province. Some CHBs were provided with training and instructional material as to how to complete the plan from their RHBs while others were given no instruction or information regarding the project. Therefore, the amount and type of information presented in the reports varies throughout the province. This presented difficulties in summarizing the issues to adequately reflect the CHBs intentions and recommendations.

In light of the above limitations, the following recommendations for the future were presented:

- Provide the CHBs with tools and advice as to how to complete a community health profile and needs assessment
- Develop standardized methods of data collection

- Provide adequate financial and human resources to assist the boards in researching and writing their reports.

Community Health Board Issues

Health Promotion, Education and Disease Prevention

All of the CHBs referred to some facet of health promotion, education and disease prevention in their plans. Most of the boards indicated a need for resources to provide education to the public regarding healthy lifestyle choices and the types of resources available within their communities to assist with healthy living, as well as information as to how to access these resources. Several communities would like to develop educational programs regarding such issues as smoking, nutrition, etc, or the creation of wellness clinics, but do not have sufficient resources to do so. Many CHBs commented on the lack of funding available for health promotion initiatives. (For example the West Hants Community Health Board Plan quoted statistics indicating that only 10% of health care dollars are earmarked for health promotion and prevention.) It was also mentioned that cardiovascular diseases and cancer are two of the most common causes of death in Nova Scotia. Both of these diseases have been linked to lifestyle choices. Therefore if programs were developed to assist residents in making healthier choices to prevent these diseases, significant savings would be recognized over the long term. Several of the CHBs referred to a study indicating that for every dollar spent on prevention the health system would recognize seven dollars in savings.

Another facet of health promotion and prevention discussed frequently in the plans was the availability of community recreational activities and resources. The communities indicated a desire to expand and enhance their current recreational facilities and to develop methods to ensure recreational programs were not too costly for lower income individuals.

Strategies for Action:

Some of the most commonly suggested strategies for action on this issue included:

- The creation of a position for a community health awareness co-ordinator.
- The creation of a community health services directory, listing all of the health resources
- Non-emergency information line for health questions
- The development of or enhancement of a currently existing multi-service centre
- Provide resources to increase and enhance the availability of primary health care services

Home Care Services

Several aspects of home care services were referred to in all of the community health plans. Most of the CHBs indicated that this issue was of a priority for their community. Some aspects of home care which were referred to included:

- Acute Care Services at Home: Several of the boards mentioned the availability of acute care services in the home as a significant issue. Problems cited included improper discharge planning, poor communication to clients as to what they are to expect from acute home care services, and inconsistent eligibility requirements.

- Non-Clinical Services: The quality and level of non-clinical services varies throughout the province. Most of the boards cited a need to provide services such as housekeeping, friendly visitor programs, assistance with ADL's etc. It was mentioned that if these services were adequately provided some other problems in the system would be avoided. Two examples cited included: unnecessary injury to those people who may to try to exceed their physical abilities doing household chores, and premature institutionalization of seniors due to the fact they are not provided with adequate supports to maintain their independence in the home.
- Poor Co-ordination of Services: Several boards indicated that their residents had indicated dissatisfaction with the manner in which home care services are organized and delivered. There are gaps in the systems and often times clients have to incur multiple assessments and a duplication of some services before or if their needs are adequately met.

Strategies for Action:

Strategies suggested to overcome these difficulties include:

- Conduct an external review of Home Care Nova Scotia's polices and procedures
- Encourage and educate acute care facilities to conduct better discharge planning
- Provide education to clients regarding the level of acute care services which are to be provided in the home
- Provide funding for non-clinical services
- Provide financial support to low income individuals to assist in offsetting the cost of home care services
- Enhance or develop palliative home care programs
- Provide respite care for family members and other caregivers

Mental Health Services

The types and severity of issues surrounding the provision and availability of mental health services varies throughout the province. The most significant differences are seen between the rural and urban community health boards. Some of the more urban communities mention long waiting lists for services and lack of supports for families and other caregivers of mental health clients. Urban areas also refer to the lack of preventive services, which could help offset the severity of mental health problems. For example, mental health counseling should be available for youths to access before they are in a crisis situation and services should be available after office hours. There is also a need to educate the public regarding the nature of mental illness so that clients will seek help in a timely manner and not avoid seeking treatment due to the stigma associated with mental illnesses. In the rural communities the problems regarding mental health services can be much more severe. CHB documents indicate that there are insufficient services for treatment and follow up of mental health patients. The distance between some rural communities and treatment centers presents barriers to access. The lack of specialized services for youth and children was also presented as a significant concern for both rural and urban communities.

Strategies for Action:

Mechanisms suggested to improve the delivery and availability of mental health services:

- Satellite clinics for rural areas
- Educate the public regarding the causes and effects of mental illness in an attempt to reduce the stigma associated with the disease
- Extend hours of availability of mental health services in communities
- Provide support programs for families and youths to help prevent serious mental illnesses induced by stress and lack of a support network
- Increase the availability of supportive housing options for the mentally ill who are being placed in the community
- Lobby the government to resolve economic issues, which indirectly contribute to mental health problems such as low income and lack of employment opportunities

Seniors Services

The population of Nova Scotia is aging. As the population ages and life expectancy increases the health care system will be required to provide services for a significant portion of the population over the age of 65. Several of the community health boards presented concerns regarding the availability of services for seniors. Although some seniors issues were referred to in the discussion of home care, some other issues were mentioned in the plans that warrant a portion of this discussion. CHBs mentioned concerns over the type of housing provided for seniors. If seniors are to be maintained in their homes, then housing options, such as senior complexes, need to be equipped with adequate structural characteristics. In addition to avoiding premature institutionalizing of seniors, the system must be set up as to avoid institutionalizing people in their own homes. There must be adequate opportunities for recreational and social activities as well as transportation to ensure seniors are able to attend these activities. As the traditional family continues to change and our society becomes more mobile, a number of seniors will be without family members to care for them. Therefore they will need to rely on the services provided within their communities to assist with daily living. Some community health boards in rural areas expressed concerns over insufficient numbers of Level II and Level III care beds in facilities

Strategies for Action:

Some mechanisms suggested to help assist an aging population include:

- Improvements to home supports and home care as mentioned previously
- Improve and expand the types of housing options currently available for seniors
- Resources for the development of seniors programs
- The provision of respite care

- Training for caregivers and home support workers
- Development of transportation programs
- Development of educational programs aimed at seniors in areas of health promotion and prevention such as nutritional counseling, correct ways to perform ADL's etc.

Emergency Health Services/ 911 Services

Several of the rural comminutes indicated difficulties with the level and quality of emergency services provided. However, it is important for readers to note that the emergency health system in this province has undergone significant changes in the last few years. Some of the problems cited with the system were presented in documents written by the CHBs between 1996 and 1999, therefore attempts to remedy some of the problems mentioned may already exist. However, due to the severity of the consequences of possible inefficiencies in the delivery of emergency services, a summary of the concerns presented the CHBs is provided.

Some of the rural communities expressed concerns regarding the level of training provided to "first responders" (volunteer fire fighters etc.) These communities also expressed concerns over delays in response times due to the location of ambulance bays, improper civic identification of houses and roads, conditions of highways and difficulties in communications between 911 dispatch and ambulance operators. Both urban and rural communities expressed concerns over improper use of the 911 service. Some strategies suggested to overcome these problems include:

- Review the location of ambulance bays in communities according to the location of emergency calls for service
- Initiate a pubic campaign regarding the proper use of 911
- Provide "first responders" with the proper education and training (i.e. CPR advanced first aid)
- Lobby municipal governments to ensure civic addresses are clearly identified

Services for Youth

Many of the community health boards indicated the importance of the availability of services to support the youth in their community. However, only one CHB presented a concise definition as to what portion of the population is included in the term "youth". Based on the discussions in most of the plans "youth" usually refers to those aged 12-19 or those under the age of majority. Support services for youth were seen as an important mechanism for assisting youth in crisis situations. Educational programs to prevent addictions and the use of alcohol and drugs were also mentioned. In one rural community, the community health plan indicated that the presence of after school programs and structured recreational activities could prevent youth from engaging in potentially dangerous activities. Since an investment in youth is an investment in our future, programs and initiatives geared to this portion of the population were deemed relevant to improving the future health of communities.

Strategies for Action:

Strategies for action included:

- Providing funding for recreational programs for youth

Workbooks

Introduction

Respondents were asked to describe how nine services, which are not health services, affect respondents' health, using examples from the respondent's communities. The nine services were:

- Employment
- Education
- Income support
- Housing
- Social support networks
- Clean air and water
- Transportation
- Recreation
- Policing and fire services

Employment

Rather than cite community specific examples of how employment affects health, respondents tended to prefer to describe – often quite forcefully – the broad effects of loss of employment on individuals and community. Frequently the effects were described in relation to perceptions of self worth, stress on the family unit and personal empowerment.

> *Unemployment and underemployment can lead to a number of health issues including substance abuse, violence, depression, etc.*
>
> *Employment affects self-esteem, which affects all other aspects of people's life*
>
> *Unemployment means stress. May promote alcoholism, break down of family, suicide, etc.*

Respondents also commented on the relationship among employment, financial stability and health.

> *"Stress from unemployment; poor diet from lack of funds; financial constraints housing (and) clothing...*
>
> *People cannot afford to buy proper food and medication.*
>
> *Employment affects income and ability to provide healthy food, shelter, and medication.*

Respondents noted that employment has health beneficial fringe benefits.

> *Unemployed persons generally do not have a comprehensive health plan.*

Even though respondents saw employment as being a determinant that improves health, they also understood that with the good might come the bad.

> *Work means higher risk of injury*
>
> *In some places of employment, there are conditions that cause illness.*
>
> *High incidence of repetitive strain injury in fish plants.*

The fishery is still an important economic touchstone for Nova Scotians. As noted, it can be tough on its workers. Respondents also noted how bad times in the fishery affects the health of Nova Scotians.

> *Downturn of fishery (equals) increased rate of alcohol and drug abuse*
>
> *Fishery closed ... no work for the people*
>
> *Very few (other) employment opportunities. Necessary to leave community, relocate or travel long distance*

Education

Education's importance as a health determinant was clearly recognized by respondents. As with employment, they preferred to speak of its sweeping importance rather than community-specific examples.

> *Education is the single most predominant factor in determining whether or not people will live in poverty - increased poverty (means) decreased health.*
>
> *Better education ' job opportunities ' better health*
>
> *Education means more awareness, ability to make better choices, better employment.*

The theme of appropriate health choices being related to education was noted by a number of respondents, who felt it underscores the need for ongoing wellness and prevention education in the school system.

> *Without proper knowledge of health needs, people continue making poor health choices (addictions, unwanted pregnancy)*
>
> *Education and knowledge is a proactive strategy - prevention is a key. The school curriculum does not emphasize healthy living. .*

There were frequent comments related to the relationship among education, literacy and health.

> *Lack of education can be a stumbling block to some persons ... if they can't read; they cannot understand medications or good health teachings. A person misuses medication due to inability to read label.*
>
> *We have a low reading ability in our area. Sending out pamphlets that people can't read or understand is useless.*

Respondents also recognized that there are good things happening in the schools with respect to health.

> *Not all things can be taught at home. PDR, Sex Ed classes allow choices*

There were frequent comments about the need for the educational system to "practice what it preaches" with respect to healthy choices.

> *Coke machines (in Inverness Academy) and the advertising on them and poor food served in some schools. Air quality may suffer due to cheap construction, short cuts, poor site choice, etc.*
>
> *By having pop, candy, fries, pizza, chocolate milk in the schools we as a society are saying, "these are good foods, kids."*

A variant of this theme is that children need to draw on the schools for health through breakfast programs, access to inoculation and similar services.

Occasionally respondents would comment on how their own educational experiences have helped them lead a healthier life.

> *Well educated, so we do a lot of exercise and reading re health*
>
> *RN training makes me an active participant in decision making regarding my health and my family as well as input in my community and jobs.*

Income Support

While respondents tended to be more specific in their consideration of income support as a health determinant, there were frequent statements regarding the sweeping nature of the relationship between income and health.

> *Too many children and adults live below poverty line resulting in poor diet, housing and low self esteem.*
>
> *Lack of income has a negative impact on health and therefore health care costs rise. It leads to poor nutrition, risk taking behavior (leaving children unattended, smoking to "relieve stress") non-compliance in medication usage*
>
> *Welfare beats starvation and malnutrition. Children get sick if not fed. Soup kitchens open up.*

Income supports and their role in an aging population was a popular theme.

> *When oil, power, taxes and food are paid for, seniors have little left from their monthly income.*
>
> *Could be needed. Household help, house and yard upkeep, so I could stay in own home*
>
> *Fixed income limits choices re health care, nutrition, and transportation.*

Our changing economy and highly competitive workplaces were seen as affecting income support mechanisms.

> *More assistance is being sought due to industrial losses and job loses. Financial pressure results in increased family violence, suicide, poor coping skills, poor self worth.*

Respondents seemed to generally support the concept that income support is an appropriate activity for governments to undertake, particularly given income's importance as a health determinant. Social assistance, employment insurance (EI), the Atlantic Groundfish Strategy (TACS), and Canada Pension were frequently mentioned as important to ensuring a basic income. There were criticisms and suggestions for change, as well.

> *TAGS has greatly helped our county. A better way would be to create more employment.*
>
> *Social assistance support not enough to live on. No supports for dental, eye care.*
>
> *There is no income support unless you are on welfare. I make $1000.00 a month and I need help and can't get it as I have a mortgage.*

Respondents noted frequently that food banks and school breakfast programs were important to assuring the health of the poor.

> *Availability of breakfast programs in school, greater demands for. Also greater demand for food bank. Increased sponsorship of families for Christmas*

Some respondents noted that income support mechanisms are considered by some to be counterproductive and invite abuse.

> *Only if willing to earn (legally) part of income, otherwise wasted.*
>
> *Nobody gets a free ride. Working to earn EI benefits or social assistance an excellent way to learn work ethic and enhance community resources.*
>
> *Essential but needs to be properly monitored to reduce fraud, waste, restrictions on alcohol / tobacco / lottery purchases*
>
> *Income support is fine, but it gets wasted. Poor footwear, hygiene, poor diet choices*

Housing

As with the other determinants, respondents took a fairly broad view of the role of housing in health. Their perceptions of the role of housing was couched in terms similar to the ones used to describe employment; that it is an essential part of health.

> *Low grade housing leads to unhealthy life, being exposed to dangerous moulds, building materials (asbestos), inadequate heating can escalate illnesses. Homelessness is devastating*

> *Without appropriate housing, mental and physical health deteriorates.*
>
> *Good housing makes for better health.*

Just as often, respondents spoke of the importance of quality, subsidized housing opportunities.

> *Adequate housing needed in order for people to be able to work on health issues. Need subsidized housing for low income.*
>
> *Low transient or relocation shelter housing for those who travel and are on low income. Shelter with advocates to help find permanent shelter. More low income housing for those less fortunate.*

Some respondents mentioned barriers, other than income, to adequate housing.

> *The needs of those with dementia or mental health issues need special attention.*
>
> *Lack of housing for mentally ill, mentally challenged and seniors, results in people being placed away from the support of their families and community*

As was the case with income support, concerns were expressed regarding the potential for abuse of subsidized housing.

> *Small, single rooms. Fire proof, vandal proof but shared bathrooms, TV, kitchen, transport and food stamps only. Otherwise, too much abuse.*

The importance of a good housing inventory was seen as affecting health through other mechanisms as well.

> *Newer homes that are so airtight and have poor ventilation or air exchangers that don't work properly contribute to environmental problems such due to moulds, etc.*
>
> *Not enough new housing to attract new people to move to the community.*

Those who spoke of appropriate housing resources in their own communities made frequent reference to local senior citizens' complexes, nursing homes and seniors apartments as being important.

Social Support Networks

Respondents spoke of the importance of the universal need for help and the importance of community.

> *We all need someone! Without social supports we have more depression, stress of loneliness, fear, anxiety.*

> *Good social contacts (family, spouse, and friends) have a positive effect on health.*
>
> *People in the community support others in crisis*

Many examples were given of groups and organisations that provide social supports.

> *Food banks, Lions, Legion, Buffalo supply assistance*
>
> *Transition House, Maggie's Place in Amherst are a key to improved life styles.*
>
> *Work finding groups are very important and help bring self-esteem to the unemployed. Palliative care support groups and cancer support are also very important on the mental health of all family members.*
>
> *We have many, many support groups in Liverpool, NS, which are greatly used.*

Social support networks were not seen as universally available, and there were calls for improvement.

> *More childcare needed for working poor and disabled children, esp. in rural parts of county*
>
> *Community is poor - no social spots for family. Our social conscience rests with elderly who are carrying burden for young people. Need to rebuild.*
>
> *Help lines in the community have discontinued due to a lack of funds.*

Very few respondents spoke of abuse of social support networks.

Clean Air and Water

It was clear to some respondents that clean air and water are significant determinants of health.

> *These are basic to the rights of Canadians*
>
> *Basic survival need - should be high quality*

There were calls for a clear government presence in the maintenance of a clean environment.

> *Always important but should fall under provincial and federal testing*
>
> *We are used to clean air and water in NS. This is to be protected at all costs.*

Respondents frequently identified local issues. The recent media attention related to elevated trihalolmethane levels in chlorinated drinking water supplies made an impression on some respondents.

> *Problems recently identified in water supplies in Shelburne County and other areas.*
>
> *Bridgewater bladder cancer scare.*

There were other clean water issues reported including:

> *Road salt water contamination.*
>
> *The use of fertilizers and aerial sprays for apple orchards have polluted the rivers in the community*
>
> *Harbour clean up??? We pay but no result!*

Respondents also commented on a number of local clean air issues.

> *The air from the pulp mill and other industries contributes to lung disease, asthma*
>
> *Central Kings High air problems driven up costs for education and health.*
>
> *Does the fact that we are in the midst of toxic waste put us at risk for more cancer and premature death? Most definitely!*

Recent improvements in air and water quality, as well as those who are responsible for them were recognized.

> *A number of coffee shops and restaurants have adopted a no-smoking policy.*
>
> *In Liverpool, the plants are constantly upgrading to keep the air clean. We're also testing our water regularly.*
>
> *Tatamagouche water utility.*

Several respondents commented that especially in rural areas, air and water quality is not a major concern in rural Nova Scotia.

Transportation

Respondents readily recognized transportation as a health determinant.

> *Lack of transportation to primary health care and prevention initiatives is detrimental.*
>
> *Increased ability to access necessary services and to participate in community functions*
>
> *Scarce dollars used for transportation for health care in rural areas - leads to choice - eat or get services*

Poor transportation resources in rural areas was a common theme.

> *Loss of trains and cutbacks in bus service make it difficult for many people to travel to city-centred health services*
>
> *No transportation available in county for seniors, disabled or low income*

> *A huge problem in rural areas and for those with a disability or dementia.*

And there were frequent calls for improvement, particular with respect to access to specialized services.

> *Transportation to Valley Regional is non-existent! Low income and mental health clients need a way to access care without spending all their cash!*
>
> *Transportation to and from Halifax can cause health risk.*
>
> *Need transportation to Halifax daily, with time for appointments.*
>
> *Long distance to care in Halifax from Yarmouth. Poor and unfit roads, sometimes.*

Respondents who live in communities with public transit systems spoke of that service being beneficial to health. Transportation services for the disabled were frequently mentioned and praised.

Recreation

"A sound mind in a sound body" summarizes the way respondents view recreation's role as a health determinant.

> *Better physical condition promotes increased physical health and mental health.*
>
> *Promotes healthy life style - exercise reduces stress as well as maintains muscle and bone mass.*
>
> *Exercise reduces cardiac disease, diabetes and promotes a feeling of well being.*

Cost and distance were often cited as barriers to recreation.

> *We have but cannot afford so children don't get the opportunity for these.*
>
> *If a student wants to join any varsity team they have to pay $100 per sport. Rule out any low-income family.*
>
> *Cost is prohibitive for the poor.*

Respondents often spoke of the need for more facilities.

> *Not enough money or importance placed on recreation and its many positive side effects.*
>
> *More recreation opportunities needed for youth in the smaller towns and villages.*

Just as often, respondents said that they were happy with their recreational opportunities.

> *Community recreation facilities have expanded their programs to promote healthy activities.*

> *Walking program by CHC has increased numbers of people walking.*
>
> *Curling clubs, soccer clubs - big in Valley even for women.*

Not everyone felt that recreation needs to be a spending priority.

> *Too much money for recreation. We need more for health and education.*

Policing and Fire Services

Respondents were again very clear in their understanding of how the availability of these services affects health.

> *Safety is one of Maslow's greatest needs. Fear affects all aspects of an individual's physical and mental (health).*
>
> *People need to feel safe.*
>
> *Important for our peace of mind.*

Respondents' comments were almost evenly divided between praise for local emergency services and doubts or criticism of them. Those with praise mentioned the 911 reporting service and the role of volunteers in rural emergency service.

> *We have an excellent RCMP detachment and a fire department that responds quickly to any emergency.*
>
> *Fire department has good response time and very helpful.*
>
> *We have both (thank God).*

Comments with a more negative tone tended to mention the RCMP and training for volunteers.

> *Overall good, but feel that using RCMP service for towns has diluted our rural police services. Lots of times there are only one, maybe two officers to cover all Yarmouth County.*
>
> *Would need more training for our dedicated volunteers in our rural areas.*
>
> *Fire service in rural areas will not survive if training can't be provided. People need skills.*
>
> *Not easy to get RCMP fast on weekends, we have own fire hall*

Several respondents commented on the need for homeowners to identify their homes with a civic address sign.

Other Questions

We asked a series of questions that were open; that is, they did not ask participants to comment specifically on a clinical service or on an issue related to broad determinants of health. They asked for an open response by the participant.

What vision do you have for health in Nova Scotia?

Responses to this question tended to reflect one or more of five major themes:

- access,
- prevention,
- community based,
- affordability, and
- equality.

Adequacy and the need for continuing education were additional themes.

When speaking of access, respondents said they want services within easy reach.

> *Essential services should be available in every district. We should not have to travel out of province to obtain appropriate health care.*
>
> *Health care available when and where it is needed.*

Prevention, and most of the other themes, was frequently mentioned in association with access.

> *Easy access for all to learn prevention and receive preventative measures to attain a healthy mind and body.*
>
> *An improvement in our over all health in prevention of illness and that everyone has access to health care when needed.*

Prevention was also mentioned as the sole element of a vision.

> *Nova Scotians begin to experience a sense of well being whether 6 or 60. Learning to adjust lifestyles to enhance health and have the information available to make informed decisions from a very early age.*
>
> *A broad vision of health as outlined by the determinants. When money is put into health it is always put into acute care. Does this have a long-term effect on how healthy Nova Scotians are? I believe that other services could improve health in the long run.*

Respondents frequently commented on their desire to have a say in the management of health and health care in Nova Scotia. They said that community orientation and community control are important elements of a health vision.

> *Health care must be community based, participatory, with needed services here. We must provide education in home, at school and in the community on all aspects of physical and mental health.*
>
> *A system which focuses both on prevention and cure, one which is affordable, one which spinals from the community, not down from the center.*

Affordability was often mentioned as an element in a health care vision, sometimes alone and sometimes in combination with other elements.

> *Affordable heath for all.*
>
> *To provide adequate and affordable health care and preventative education to all Nova Scotians – a prescription is not worth the paper it is written on if people cannot afford to buy it.*

Achieving health and getting access to health care must be equitable, according to many respondents. Some comments respecting equality reflect its importance as a core element of health; others are worried that our system plays favorites.

> *Everybody have the same chances for a good education followed by realistic job opportunities and adequate care when health fails or we grow too old to be in the work force anymore.*
>
> *That everyone, whether rich or poor, status or non-status, be treated on an equal basis when you are in the hospital or any other area of health care. (Sometimes who you are gets faster and better results.)*

Some respondents used this question to comment on what they perceive as inadequate service levels or resource shortfalls.

> *More doctors, less waiting time for surgery and perhaps appointments with specialists. Nice to see more hospital beds open and more nurses.*
>
> *It's not good as I work in health care and the most cuts have happened to the low end staffing in services while they seem to feather the nest up the management ladder. How can we have a sturdy health care system with no foundation to hold it up?*
>
> *Please let present services continue to expand, and never, never be restricted. To often now, waiting periods for appointments and/or operations are far too long.*

If you could have only three services that affect health in your community, what would they be? (That is, what are the three most important services for you?

The most frequently mentioned priorities were:

- Hospitals: Frequently, the hospital was mentioned as offering a variety of services in addition to acute care.

- Prevention: These services would include youth services, activities aimed at reducing pollutants, and education.
- Providers Having a doctor or nurse practitioner or nurse available for acute care, support through a chronic illness or to be available for counseling.
- Ambulance and emergency room services.
- Home care.

In excess of 80% of respondents could find their three choices in the above broad categories. It is interesting to note that four out of the five most common priorities are related to acute care services.

Health promotion

This question had four components:

- What information do you need to stay healthy?
- How do you get this information now?
- What further information do you need?
- How would you like to get this information in the future?

Respondents chose to answer all, some or none of the four components.

The most commonly identified current information needs were general information on wellness and prevention, followed closely by diet. General medical information and exercise were also mentioned as current information needs. The sources for this information were most frequently a health care profession (usually a doctor) or the print media (newspaper, books) and followed closely by the broadcast media (radio and television). The internet, pharmacies and schools were also mentioned as current sources.

> *I feel there is a fair amount health information at doctor's, hospitals, clinics, and (on the) T.V*
>
> *Most information comes from the family doctor. Diet and exercise in school. Information about health at community events.*
>
> *Proper nutrition information, exercise information. I receive this information currently, through doctor, TV news*

Fewer respondents identified future health information needs. Wellness and prevention information was most commonly mentioned, followed by diet and general medical information (such as new developments in treatment). Respondents showed considerable interest in clinics, seminars and other public meetings as a future source of information on health and wellness. The Internet was mentioned as helping with future needs and there was frequent mention of the establishment of a toll free number that would connect to a central source of information on health, wellness and prevention.

> *I believe that a regional health clinic that would educate the public would be very helpful.*
>
> *I feel community-based partnerships that take place in individual communities will bring people out to education sessions etc but transportation and publicity is a must.*
>
> *Must bring to people's homes ... TV, internet. Teach in workplace, schools, and daycare (people will not go to meetings, formal presentations).*
>
> *1-800 or internet sites to connect to resource people.*

A few respondents indicated they don't want any more information. Some mentioned that promotion is pointless unless the individual takes some responsibility, and that promotion, to be effective, must start with the young.

> *Health promotion is a relatively new concept so only those interested will utilize the information. The need is to start at elementary level and educate slowly and steadily the new generation.*
>
> *Most of us already know how to be healthier than we are; we don't act in healthier ways...*

Illness and injury prevention

Respondents were asked to describe how Nova Scotians could do a better job of preventing illness and injury. Education and leading a healthy lifestyle were the most common answers.

The need for health and safety education was the most commonly identified area for improvement.

> *Education on injury and illness prevention so the people know and understand about their own health.*
>
> *Educate, educate, educate. Advertize on TV, work with school children, and hire more people to work in this area*
>
> *Teach people how to take control over their own health through courses, workshops, (and) community meetings.*
>
> *We need to make all people aware how easily injuries occur and how easily many, many illnesses may be prevented. Have promotions regarding workshops, clinics etc. where we learn what is available, when and where.*

When speaking of healthy lifestyle, respondents often mentioned the need for individual responsibility.

> *We can wise up to what is good for us, what we feed our bodies and what we breathe in.*
>
> *Wake up and quit being non-responsible.*

> *Encourage a healthy lifestyle by all means of communication (discourage smoking, highway safety, etc.)*

Respondents said that safety legislation, particularly in the workplace, is an important component of illness and injury prevention.

> *By following safety rules in work place. Better enforcement of Safety rules by management, teaching and enforcing better driving habits on our highways, by setting better standards in our building codes so our new public buildings won't get "sick" and cause the people who work in them to get sick.*
>
> *Mandate health and safety training. Assist employers and volunteer associations to expand their program (e.g. St. John Ambulance, Red Cross) incorporate health and safety training in their core course menu.*

Healthy environment

Respondents were asked to identify the first thing Nova Scotians need to do to help develop a healthy environment. Most respondents interpreted this as meaning what environmental factors can be modified to reduce risks to health. Some interpreted the question as meaning how can our societal attitudes be changed to have the totality of our environment change to allow for better heath.

Reducing smoking and ensuring clean air and water were the most frequently identified environmental factors.

> *Drive fewer cars / Smoke fewer cigarettes. Use less wood burning in homes. Legislate pollution controls for factories, saw mills, etc.*
>
> *Plant more trees; clean up such pollutants like Halifax Harbour, Sydney Tar Ponds, Stop storing hazardous waste in unprotected areas. Provide better public transit systems to cut down on our pollution.*
>
> *We need to ban smoking in all public places and force smokers outside – make it unacceptable to smoke in public.*

There were frequent references by those looking for clean air and water to a need for more aggressive enforcement of environmental laws.

Making society as a whole a healthy environment was a concept that was expressed in a variety of ways.

> *Find out who we are – what our values are – and set about bringing the culture in line with this.*
>
> *Use good judgment but the government can buy not everything for us. People must look after their communities and themselves as well.*
>
> *We have to appreciate and build on what we do have. Make the work environment healthier.*

> *Connect with the environment ... see it as the life giving source that it is and recognize how interdependent all life is.*
>
> *Each person being responsible in their own occupation, in and around their own home. Working with young people, setting good examples.*

Healthy living

When asked, "How do you think we can live more healthy lives", most respondents answered by saying we need to exercise more, eat better and stop smoking.

> *Avoid habits (smoking and drugs) that harm health. Make every effort to get regular and proper food. Make sure one has enough exercise to keep body healthy.*
>
> *Bien manger, bien se reposer et faire de l'exercise règilièrement.*
>
> *Take responsibility for our own health. Improve life style. Diet, exercise, alcohol, tobacco, safety, etc*

Many respondents placed diet, smoking and exercise in a broader, healthier lifestyle context.

> *Change attitudes. People must take responsibility for their life style, negative as well as positive behaviours. The doctor can't cure us of everything!!*
>
> *Stress seems to be a large part of our health problem ... fast paced life style seems to be the way. Fast foods, pre-prepared foods, faster computers, internet, faster cars, children being pushed into organised sports and groups, parents rushing from one thing to another – we need to slow down and enjoy life!*
>
> *More focus on leading balanced lives – more physical activity and less stress.*
>
> *Practice wellness ... lots of exercise, diet, no smoking, and alcohol, belonging to enthusiastic groups. Helping others. Regular check ups by family doctor.*

Wise Management of Resources

Many respondents to this question interpreted it as asking how the province's natural resources (forests, gas, and coal) could be managed to provide the foundation for a healthier society.

> *No more clear-cutting. Must have proper forest, sustainable management. Keep farm, fish, wood, oil, and gas resources for Nova Scotians. Use and jobs encourage people to fish and farm especially along south shore.*
>
> *Control of forestry or any other material production to replaceable limits. Flying over NS last week was appalled at the extent of recent clear cutting.*

Others interpreted the question as asking how the province's healthcare resources could be better managed. Community involvement and control of resources and new management structures were popular themes.

> *Ongoing accountability. Smooth administrator procedures. Not building empires at government levels.*
>
> *Increasing community services, monitoring emergency services by ensuring use of emergency services is properly controlled.*
>
> *Each community or county should have their own say in the resources they feel suit their needs.*

Some commented on the need for greater cooperation and coordination.

> *Community based partnerships – the community, local health organisations or hospitals, health department and Health Canada can do a whole lot inexpensively rather than each trying to do its own thing*

A few commented that entirely new management models were needed for the health care system.

> *Get away from the medical model for supporting health, since it is too costly and too hierarchical to be reasonable, and discourage inappropriate and unnecessary interventions.*

Public Participation

Overwhelmingly, respondents said that the best way to ensure their participation in health related decisions is to listen to what they are saying. Respondents indicated they are tired of being asked the same questions over and over again; and they are very skeptical that anything will come of their comments and suggestions.

> *If when these surveys or questionnaires were completed some one paid attention to the answers. Nova Scotians have spent lots of time and effort telling governments what they want or what they would like to see happen but it appears that is "taken" information and the government has its own agenda.*
>
> *Seeing local suggestions taken seriously and not just thrown in the trash. Again and again the public is asked for input but it is (or has) been ignored.*
>
> *Is our input helpful? Is it useful? Does it actually have any affect?*
>
> *The Council politicians listening to those who are working / volunteering in the system. Don't have your agenda. This workbook is slanted and questions are leading, some ambiguous.*

Allowing more local control of resources and community management or oversight mechanisms were often mentioned.

> *Being on a committee to look at how mainstream and complementary health care can be integrated on a district level.*

> *Our present system of volunteers on Community Health Boards and the continuation of those boards to bring information and idea exchange to local communities.*

Some respondents thought that alternate methods of getting input should be examined.

> *Participation via the Internet – too few evenings left free to attend meetings.*
>
> *Simple questionnaires to be filled out and returned with telephone or power bills once a year.*

Social Justice

Respondents were asked to identify an important policy to have in place to ensure that all Nova Scotians have the chance to be as healthy as they can be. Overwhelmingly, the respondents spoke of the need for equality achieved through broader access.

> *It has to be fair and equal to all. I feel our out patient system is terribly abused, part of this maybe from not having enough doctor. However there are a large number of people who go to out–patients looking for a quick fix.*
>
> *Equal access to all areas of health. Reliable information. Nova Scotians have the right to good health but also a responsibility to look after their own health.*
>
> *A policy that would ensure that every individual is treated on the same level in every community in the province. Stop centralizing everything in Halifax.*
>
> *A good question – do away with two-tier system, we are all equal. Judge by health need not by who the patient is.*

Education and promotion were also seen as means to achieving broader health.

> *Keep informing people of new medications or any new diseases and give out good sound health care advice, as it becomes available.*
>
> *Promotion of improved health habits by local radio and a greater role for schools, libraries and community centres to further educate everyone on a better way to live.*

Public Meetings

Findings from Public Consultation

Public consultation was held across Nova Scotia. In some places, it seemed to be mostly health care providers in attendance while in others it was a combination of health care providers and heath care consumers. A different format was used in some instances so there was some inconsistency in the type of information from the sessions. However, there were a number of themes that arose. The findings from the public consultations are presented under those themes.

Staff shortages

In most communities, there was discussion relating to the shortage of staff in the health care field. Many commented on a lack of general practitioners and the difficulty in finding a family physician. Some participants indicated they had to travel to a different community (or even a different province) to find a family physician. A number indicated that their communities were on the edge of crisis regarding availability of physicians. While there was recognition of the recent efforts that have been made to attract physicians to rural areas, it was felt that there is still much to be done in this area. Participants also spoke of a shortage of nurses and there is a belief that casualisation is one cause for this. There were comments that nurses were leaving because they can not find full time employment in the province. Participants also worried that there are not enough nurses being trained in the province to replace the number who will be retiring in the next few years. Because of the shortages and because of no relief, health care staff is perceived as being overworked and at risk of burn out. Participants commented:

> *Nurses are overwhelmed, tired, run ragged.*
>
> *The Department of Health program needs a thorough review and needs to become more pro- active in recruitment and needs to work on incentives to retain services of doctors.*
>
> *A couple of days ago, I received a package from RNANS. In the year 2000, over 1000 nurses will be eligible for retirement, age 55 to 65, the average age is 47 in NS.*
>
> *Doctors, nurses, and patients are feeling the spiraling effects of shortages.*
>
> *We cannot download any more work onto the present staff and the community.*

Appropriate Use of Resources

There was concern expressed regarding the appropriate use of resources, particularly human resources. In particular, it was felt that greater use should be made of nurse practitioners. Participants felt this approach would relieve some of the load on physicians, thereby making it easier for those who need a physician to access one. There was also mention on the administrative burden that have been put on some practitioners which decreases the time they can actually spend on the providing health care or prevention.

> *Having the Public Health nurse standing at a copier for hours on end takes the nurse away from the patient.*
>
> *We now have more administration in the system than we had 6 years ago and we have had cuts in the system and deliverers.*
>
> *At least 70% of OPs are being triaged by doctors; this is inappropriate use of physicians.*
>
> *If legislation prevents nurse from doing what s/he is perfectly capable of doing it should be changed.*
>
> *There's no clerical help in the hospital; the nurses are providing clerical work.*
>
> *Nurse practitioners could be perfectly adequate gatekeepers to health care system.*
>
> *Nurse Practitioners work in Rankin Inlet, why can't it be done here?*
>
> *I spend more time nursing the system than nursing the patient. Patient care is directed by space and resources - not by the needs of the community.*
>
> *We need 24-hour clinics staffed by nurse practitioner for the things that don't need a MD. Sometimes just need reassurance, better human resource management. Better use of LPNs, RNs,*

Rural Concerns

There were a number of issues raised by rural areas relating to the provision of services. These issues were the need for, and accessibility of, transportation, the way in which decisions are made and equality of services.

Transportation

In many areas, participants spoke of the need to travel to access services such as cancer treatment and dialysis. They talked about the cost of this, the burden it created on family and accessibility to transportation. Participants talked about the lack of public transportation in most communities and the impact of this on many, in particular the elderly and the disabled. They indicated that these transportation gaps make it difficult for those who cannot transport themselves to access services, making it difficult to even get to an appointment. It was noted that this was basically a rural problem although the cost of transportation for those with low incomes, even in urban areas, was recognized as a barrier to accessing services. Participants also spoke of the cost of being transported by ambulance. There was general consensus that it placed an unfair burden on those in rural areas to charge for the ambulance when it was being used to transport a patient to a service not available in the local area. Some participants suggested that services could be located in rural areas and those in urban areas could travel for the service. Participants also felt that the burden should not rest on family members to be responsible for transporting patients to Halifax to access services. Participants commented:

> *If we can't make it to Halifax we die.*
>
> *If we had the services here and went elsewhere charges (for ambulance) would be appropriate but not if the services are not here.*
>
> *Should my wife be responsible for transporting me to Halifax 3 days a week for this treatment (dialysis) which is required to keep me alive?*
>
> *It's ridiculous that people have to pay for an ambulance to Halifax. It's a tax on rural living.*
>
> *Having to transport a family member from here may cost the breadwinner a day's work.*
>
> *If Halifax people had to come to Yarmouth for specialist services how would they complain?*
>
> *No reason people from Dartmouth can't come here. It's no different for us to go there. They can drive the distance. It's changing mindsets.*
>
> *The rural area heart attacks are just as important as those in Halifax. You need the emergency response within 4/6 minutes.*
>
> *Transportation is an issue. When people can't get to service, it doesn't matter where they are.*

Decision Making Process

There were a number of concerns about the decision making process. Many participants felt that decisions were made centrally in Halifax with little regard to, or knowledge of, the issues and concerns in the communities. Many spoke of the differences between rural and urban areas and it was felt that the challenges faced by rural areas are not well understood by those in urban areas. In particular, it was indicated that decisions should not be based on numbers only because small communities will always be adversely affected. As well, in some areas it was noted that physicians are not represented in the decision-making process. Comments included:

> *Halifax making decisions about rural Nova Scotia is a problem.*
>
> *Halifax needs to know that Amherst is cut off by Cobequid Pass and the New Brunswick border.*
>
> *Policies are set for the Halifax area and these are not necessarily transferable to the rural areas*
>
> *Representation on DHA's needs to be fair!*
>
> *We need to keep community control with the support of the Department of Health.*

Many, particularly those in Cape Breton, said there needed to be equity in delivery of services and this can not be accomplished by using the same rules for all areas of the province. Participants also commented that there were inequities in the way funding was allocated. There was a feeling in many areas that those who did well were punished and any savings used to reward those who did not manage their budget well. The ways in which this was expressed included:

> *40% of province lives in Halifax/Dartmouth but 60% of mental health budget goes there. We deserve more money in our area.*
>
> *As a mother, daughter, granddaughter, etc. I knew I wouldn't have the services I had in the city, but the level of service provided in rural areas is abysmal. We all pay the same taxes; we should all have the same level of service.*
>
> *Keep the counts accurate; the counts in rural hospitals get skewed.*
>
> *Make sure standards are on basis of merit.*
>
> *Make sure the same standards are applied to everyone, my mother and John Hamm's mother.*
>
> *No matter where you live in Hants East you should be able to expect the same services for your tax money.*
>
> *May need restorative care, progressive care - QEII does have these services but we can't get our patients into those beds, there is inequity in access.*
>
> *We are getting punished for delivering appropriate care.*
>
> *We can put the numbers up if we need to; we get docked for doing a good job.*
>
> *You need to deliver the same levels of health care and education in all parts of the province.*
>
> *Guysborough pays the same taxes, didn't accrue the debt and deserve the same level of service as others.*

There were concerns about co-ordination of services, particularly as it related to long-term care beds. Participants in some communities also expressed concern about decisions regarding the use of money raised in their communities. There was also concern regarding the level at which decisions were made. Comments included:

> *Treatment of the LTC sector is not equal in nature.*
>
> *Acute care, home care and LTC are poorly coordinated and integrated.*
>
> *Long-term care is problem - Yarmouth Regional Hospital 20 of 144 beds had long-term care patients blocking beds.*
>
> *Don't punish western region disproportionately because they lived within their budget.*
>
> *Equipment has been sent out (of our area) without permission.*

> *Administrators are making more and more decisions that were physician decisions before this time.*
>
> *The Department of Health is unilaterally deciding what the GPs can do and not do at the local level.*
>
> *The provincial government shouldn't touch local money raised.*

In two areas, Shelburne and East Hants, there was concern that residents were being forced to go for treatment to an area not of their choosing. Participants in those areas commented:

> *The ambulance won't take patient where they want to go.*
>
> *Don't let the government tell you you have to go to Truro when Halifax is so close.*
>
> *Subtle move by the Northern Regional Health Board to direct us to Truro.*
>
> *The communities know themselves best – don't disregard what they say, boundaries that are set for administration are artificial - need to be flexible.*
>
> *Truro is trying to increase the amount of work in Truro but we need to make sure we preserve our right to go to Halifax.*
>
> *When call 911 - the patient is told where they will go and the ambulance driver won't listen to the patient about where he wants to go.*

Prevention and Promotion

The issues of prevention and promotion of wellness were frequently raised in the consultation sessions. It was noted that prevention causes much less than treatment but very little in the way of resources is put to this area. Participants noted that, in particular, greater effort was needed to provide education to youth about lifestyle choices and healthier living.

> *That area (prevention) is totally lacking, those factors are the biggest factors in prevention of heart disease and stroke, those things that cost millions and millions of dollars.*
>
> *Put more money into prevention, especially youth and children to teach healthy life styles.*
>
> *Less than 4% goes into health promotion. We well know that nutrition, clean water, etc is good stuff, we don't have many incentives, or things that are accessible to many people for lifestyle choices, costs money to exercise, need people trained, in larger numbers, having free clinics for people to come and get counseling on diet, exercise, etc.*

> *It takes one person to close the barn door up front. It takes 20 to catch the horse later and maybe a professional to fix it after it's caught.*
>
> *There's an abysmal lack of opportunities and facilities for people to achieve and maintain health, e.g. rinks, swimming pools, etc.*

Volunteers and Care Givers

In many of the consultation sessions, the contribution of volunteers to the health care system was raised as an issue. Participants noted the huge contribution of volunteers and it was generally felt that this contribution is not widely recognized. Participants also noted the savings to the health care system because of the contribution of these volunteers. They expressed concern that too much was being asked of volunteers and this is contributing to burnout. Participants commented:

> *We have many wonderful volunteers in our communities.*
>
> *Community volunteers are saving incredible amounts of money with no recognition/tax breaks, etc. for community volunteers.*
>
> *Volunteers need to be recognized.*
>
> *Level of volunteerism is good; extremely important to have them in the decline of the health care system because there are not enough staff to go around.*
>
> *Many people are still in their own homes because of volunteers. Several years ago he (my husband) would have been in St. Martha's, look at the money we are saving the system as well as contributing to quality of life.*
>
> *Volunteers don't get thanked.*
>
> *Volunteers are burning out - more services are being joined as government withdraws the services that volunteers provide.*
>
> *Volunteers in this province are burnt out, you see the same faces over and over again – government loves this, it costs far less.*

Related to the issue of volunteers is that of caregivers. Participants noted that there are many people caring for children, parents, people with disabilities and the elderly. They saw a need for greater support for these caregivers, particularly respite care, to reduce the stress levels. Comments included:

> *We don't pay enough attention to care giver in home care. Caregiver needs more attention.*
>
> *Caregivers are being stressed out.*
>
> *We need opportunities for people at home to get out and give caregivers in the area a break.*
>
> *We have seniors taking care of seniors. 70 year olds taking care of their seniors.*

Poverty

Poverty was seen as an issue affecting the health of Nova Scotians. Participants noted that proper nutrition contributes to health but they went on to comment that proper nutrition is a difficult goal for many to attain. It was also noted that this is not a concern just for those on social assistance but that it affects the working poor as well. Access to medications was also seen as an issue related to poverty. Comments included:

> *Low-income people don't need Canada's Food Guide; they need the money to buy the food.*
>
> *A person with little money who can't afford drugs - little cost now leading to greater cost later.*
>
> *We don't recognize the working poor. Working poor can't afford medications and are becoming ill because physicians can't give samples.*
>
> *One in five children are living in poverty. One third of youth are unemployed and living in poverty.*
>
> *People on social services are doomed to have poor health; (they) can't get services and are blamed for having poor health.*
>
> *There are huge issues around poverty. Can't be neglected when talk about health. If can't give people dignity and self-worth and things they need to live.*
>
> *Poverty is an issue that needs to be addressed. Many needs - public health less than 3% of total budget. Hate to hear put all eggs in one basket -need to look at those who get no programs or services because they are poor.*

Waiting times

Participants expressed concern about the waiting time for services, particularly for access to specialists or to be seen in an emergency or outpatient's department. Participants felt that waiting six weeks for an appointment with a family physician or six months to a year for an appointment with a specialist was not acceptable. It was suggested that there should be more specialists travelling to small communities so their services would be more accessible. It was recognized that this then takes time away from seeing patients but they noted that it should not always be the patients travelling from the small communities to the urban centre. Participants commented:

> *My husband waited 5 hours in out patient department*
>
> *We need faster acute referrals to specialists. How can this happen?*
>
> *Eternal problems of long, long waits for diagnostic work up (BH)*
>
> *Our local doctor - you have to go first thing in am to register and then come back later for the appointment, costing twice fares, otherwise you have to wait for weeks for appointment*

> *We shouldn't have to wait a year for chronic pain treatment.*
>
> *Husband is a patient waiting to see a doctor for collapsed kidney. Have to wait another month, and it's been 6 months since his last appointment. Six months is too long to wait to see a doctor.*

First Nations Communities

Consultations were held in a number of First Nations communities. The concerns expressed were generally the same as those heard in other communities although there were some concerns that were specific to their communities. These concerns included:

- home care on the reserve;
- involvement of the native communities in the decision making process;
- better integration between government departments;
- cultural appropriateness of services provided to native people;
- respect for the input/assessment of First Nations professionals; and
- the need for health professionals, such as nurse practitioner, in addition to physicians.

Specific Services

In all consultation services, there were specific services that were named as important in the provision of health care. Advocates for a particular disorder raised many of these but a number were also raised by a variety of participants. It was also noted that many communities have an aging population and services need to recognize this. Services that were frequently named as important to the communities included:

- addiction services;
- mental health services;
- long-term care beds,
- acute care beds;
- services for brain injured individuals;
- treatment for environmental illnesses;
- nutrition counseling;
- home care;
- services for youth;
- physiotherapy;
- public health services;
- respite care; and
- palliative care.

The final one of palliative care generated much discussion in many consultation sessions. Participants felt this is a service that should be available to all Nova Scotians and they noted:

Palliative care - why doesn't Nova Scotia recognize this program?

Palliative care program should be a core service in this area as we have such a large senior population.

Death arrives for all of us; we want to make the death a good death for the individual and the family.

There were a number of comments made that did not necessarily relate to one of the specific issues but rather were general comments relating to the provision of health care. Comments included:

There needs to be a focus on the patient.

Nova Scotia and New Brunswick need to get together.

Allow seniors to choose where they want to live.

Prices of drugs are out of this world.

If you downsize - put supports in place first.

Disability is a major barrier.

Health has to be approached over the long term – don't let the government change it every time they change.

Patients are on the end of this system and they are being lost in the shuffle.

It would be nice to see youth involved in the system.

We need to recognize that each segment interacts with each other section, government needs to recognize that.

Public participation is a critical component of the health system.

What has been lost is the role of community hospitals in a community.

Summary of Findings: Major Themes

As mentioned above, input for this study was gathered from three sources: Community Health Plans developed by the CHBs, workbooks and public meetings. The processes used were shaped by the advice given by an Advisory Committee consisting of stakeholders from across organizations with key interests in the health of Nova Scotians.

The workbooks gave individuals the opportunity to answer a defined set of questions (Appendix 3) and also give free text ideas and opinions. People were enabled to participate in an anonymous way, however, many insisted on providing not only demographic information but also their own name and contact information, because of a concern that governments would ignore the pleas of nameless masses of people. One respondent's (Gerald Randall) remarks are typical of what many stated in the workbooks themselves: "I am reluctant (to participate) because I am of the basic opinion that our elected representatives have no intention of paying attention to the results of any surveys they undertake to have completed if these surveys make recommendations that do not fall in line with what they have already decided to do. …I hope I am wrong but history has not proven that will be the case". This concern was also brought up frequently at the public meetings.

RECURRENT THEMES:

Access

All of the input sources identified strong fears within the community that important clinical services would not be maintained. In particular, there is a worry that acute care services like primary care office visits (especially to family doctors), emergency services, and appropriate home and hospital care will not even be maintained at current levels, much less increased to meet needs.

Many of the inputs noted that people in both urban and rural areas are having difficulty in finding accessible family doctors to take ongoing responsibility for individual and family care.

All sources discussed issues around equity of access to services between urban and rural areas. It was felt that those in rural areas had less access to good health services than did those living in Halifax area. All sources also noted a fragmentation of services and requested that efforts be made to integrate each of the components of the health system so the pieces work together rather than against each other. Participants requested that government departments collaborate, avoiding redundant and inefficient efforts. In addition, there is recognition that primary care, continuing care, and acute hospital care services must be integrated so citizens can obtain necessary care in the most appropriate setting and with continuity of care across the various parts of the system. This aspect is very dependent on a good integrated information system.

Solutions:
We need to maintain primary care physician services by either increasing the number of family physicians or changing the model so that existing clinicians can comfortably care for more people.

One way to do this is to reduce the amount of time each physician spends doing unnecessary work. Today, doctors spend unproductive time in a variety of ways, including charting solely for the purposes of billing audits, providing face to face care when brief telephone or e-mail advice would be sufficient. Unfortunately the current predominant primary care compensation system is fee for encounter and physicians are not compensated at all for providing services that are not "face to face".

Another way of improving access to physician time is by developing community resources such as community health centres where doctors, public health nurses and other health professionals work together to provide integrated primary care services and where each patient can receive, from the same clinic, the full range of necessary services. This solution is compatible with the requests from Community Health Plans for better communication, integration and coordination of services.

For the elements related to coordination and integration of services, it would be helpful to have a fully integrated health services information service that crosses providers and government departments. Such a system must also carry valid and reliable information in an accessible way that still protects the security of confidential information. Another possible way to coordinate and integrate services is to have case management based in the community of the individual needing the services.

Health Promotion / Disease Prevention / Education

Communities want access to valuable information and learning opportunities about strategies to maintain health and prevent illness. Additionally people want access to necessary services and facilities such as health clubs, gymnasiums, swimming pools, sports and other recreational facilities.

Health promotion activities include regular point of sale information from pharmacies, healthier restaurant menus, advertising healthy life styles on television, school public health and gym programs.

Solutions:
To improve health status of members of a community, it would be helpful to examine access to important recreational opportunities for people who may not be able to afford memberships or transportation. This economically disadvantaged group would benefit most from access to appropriate recreational opportunities, since we know that poorer people are more likely to suffer from poor health.
We can encourage fast food restaurants to develop healthy, tasty, and cheap menus and encourage people to purchase healthy food. We can also help people learn how to prepare healthy, tasty and inexpensive food.

Clean Environment

Participants wanted to have clean air and water. A practical approach to this is implementation of effective solid waste management techniques (e.g. sewage treatment) especially in Sydney and Halifax. People prefer that sewage be treated before being directly dumped into the rivers, lakes, and ocean.

Solutions:

There was a clear recognition that burning fossil fuels harms our environment so government is encouraged to examine the risks and benefits of other techniques such as nuclear power, wind, water and tidal stations.

Services for Seniors

The Community Health Plans, especially those from the Western Region, were most eloquent about the need for integrated services for seniors, although it was expressed frequently from the other input sources. This includes home care and home support services to keep them in their own environment as much as possible, long term care, respite, and day programs.

Services for Youth

There was also frequent mention of the need for coordinated, integrated services for youth, with people citing high rates of teenage pregnancy, the need for hope for a better future, as well as the need for accessible recreation opportunities and education. People suggested the possibility of having enhanced programs in schools, and better community resources such as addiction services as two examples.

Mental Health Services

The importance of mental health services came out from all of the input sources. This was especially true for those who expressed concern for the welfare of youth in the province. They expressed worry about suicide rates, rates of alcoholism and rates of use of other substances as a result of problems with mental health. Some said that if we take the time and resources to deal with these issues when children are young, we could prevent crime and very expensive use of the justice system later on.

Community-Based

Throughout all of the process, we found a strong theme of people wanting the services, access and decision-making to be community-based. People noted such examples as having local management of community health centres where a variety of services and programs could be centred and managed; and the need for more authority to rest with the Community Health Boards. Some also framed it in the negative by criticising the influence of Halifax or central control of processes.

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Appendix 1

Planning

1.1 Minutes
1.2 Background Statistics
1.3 Canadian Summary
1.4 Nova Scotia Department of Health Material
1.5 Nova Scotia Health Goals & The Determinants of Health

Provincial
Health Council

Core
Services
Public
Consultation

Steering Committee

Minutes

1999- 2000

Suite 301
1888 Brunswick Street
Halifax, NS
B3J 3P7

Provincial Health Council

Core Services Committee
Minutes: September 13, 1999
9:30 a.m. - 11:00 a.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), B. Hart, Menna MacIsaac, M. MacDonald, J. Dow (Ex Officio)

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1. Definition of Core Services

Context: Core Services should be defined so people won't confuse it with standards of care. Core Services will be reviewed at three levels, community, regional and provincial.

M. MacIsaac stated that other provinces are dealing with this issue, as well. Each province designated someone to identify core services, and those people developed a list which described the core elements of health services. They are now working with the community to develop standards.

M. MacIsaac felt that the committee should communicate with the government to stay current with its decision regarding regional health boards.

A list of core services available at a community level would let people know what's available at their level and when they should seek services at another level.

2. Population-based Funding

Context: Regions could have population-based funding. This funding would be based on a region's needs by demographics. NDO's resist this type of funding because the population would decide how much funding they would get. The Minister and Deputy Minister of Health are looking into this matter.

3. Focus of Core Services

Context: Committee members discussed who they wanted input from: the government, communities, and the Department of Health. M. MacIsaac felt input from the communities would be good for primary health care.

Members felt committees could meet to work on each level of health care at the same time, and once they know what's available at each level, they could approach communities and physicians and ask what they think should be available.

M. MacIsaac will send J. Dow information on core services in other provinces for distribution to committee members.

M. MacIsaac will notify the Deputy Minister of Health that she is working on this committee.

Committee members felt they should read a variety of documents, including the Blue Print, Task Force Report, and Determinants Document, before proceeding on core services. M. MacIsaac will also provide Canadian Think Tank information on primary care, funding, and primary care and funding, together.

T. Bird requested to look at responses to the 1993 decision guide and work book for the Provincial Health Council, relating to services covered by MSI.

4. Next Meeting

The next meeting will be on September 27, 1999 at 9:30 in the Provincial Health Council board room.

Provincial Health Council

Core Services Committee
September 27, 1999
9:30 a.m. - 2:00 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, M. MacIsaac, J. Dow (Ex-Officio), B. Hart (Ex-Officio)

1. Meeting Minutes

The committee reviewed the minutes from the September 13th meeting. M. MacIsaac requested changing the second paragraph from "a list which described the core elements of health services" to "developed a list of health services."

Members felt notes should be recorded instead of minutes.

2. Core Services Spreadsheet

T. Bird suggested creating spreadsheets listing existing core services at all levels in each province. M. MacIsaak will provide a list of people to consult with in each province.

M. MacIsaak distributed a list of acute care services available in Nova Scotia. She will get information on long-term and home care for committee members.

J. Dow will obtain information on Oregon's system of health care.

3. Brainstorming Session

In a brainstorming session, the committee came up with suggestions and questions, which have been categorized (please see attached).

4. Next Meetings

The next meetings will be held on October 4, 1999 at 9:30 a.m. and October 18, 1999 at the council board room.

Provincial Health Council

Core Services Committee

October 4, 1999
9:30 a.m. - 2:30 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, M. MacIsaac, B. Hart (Ex-Officio), J. Dow (Ex-Officio)

1. Brain Storming Session Review

Administrative Components - T. Bird felt the committee should see if it needs more staffing to achieve its duties. J. Dow will look into hiring a contract researcher until a permanent researcher can be obtained.

Consulting with the Public - B. Hart suggested that the committee meet with non-for-profit organizations. Committee members felt consultations could be organized through community health boards. A draft document should be prepared to present to the public.

Advisory Group - Committee members drew up a list of advisors, consisting of 4 CEO's of the NDO's, 4 regional health board members, members of professional associations, 7 Department of Health program directors, 8 community health board members, and 4 administrators and 4 providers from the Departments of Justice, Education, Community Services and the Environment. The advisory group should include representatives from long-term care, acute care, mental health, public health, home care, primary care, drug dependency, and visible minorities.

The role of the advisory group is to provide input and expertise to the Provincial Health Council steering committee on the development of a draft document which identifies primary (community), secondary (regional) and tertiary (provincial) core services for Nova Scotians.

The advisory group will attend a two-day session. They will receive an information package prior to that session.

2. Task List for Committee

Please see attached for the list of tasks to be performed by committee members.

3. Next Meeting

The next meeting will be held on October 12, 1999 at 9:30 a.m. at the council board room.

Task List

B. Hart will contact regional health board Chairs and request a representative from each board.

T. Bird will approach the community health boards' Council of Chairs for names of community health board members to attend session.

Cost of two-day session should be calculated.

Facilities for session to be booked.

J. Dow will create matrix of names of participants in advisory group.

Choose a facilitator for the session.

Confirm attendees of session by October 18th.

Make up an information package on core services to send to people attending session.

Obtain organizational charts with names from the Departments of Justice, Education, Community Services and the Environment.

Provincial Health Council

Core Services Committee
October 12, 1999
9:30 a.m. - 2:30 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, M. MacIsaac, N. Mensink, B. Hart (Ex-Officio), J. Dow (Ex-Officio)

1. Notes from Last Meeting

B. Hart felt the second paragraph didn't reflect that the not-for-profit organizations are separate from the Community Health Boards, and that the committee would receive feedback from both the Community Health Boards and the not-for-profit organizations.

M. MacDonald stated that the Youth Secretariat was omitted from the list of departments to include in the advisory committee.

2. Task List

B. Hart contacted the Regional Health Board Chairs but has not received any replies yet.

Rooms have been booked at the Lord Nelson Hotel. J. Dow will look at prices for booking conference rooms at the Diocesan Centre.

Wayne Marsh has been booked as facilitator.

Anne McGuire and Ann Power have confirmed that they will attend the November 25-26 session.

3. Core Services in Canada

N. Mensink distributed a document she completed listing core services in all provinces.

Committee members discussed omitting the word "core" for simplicity. Nova Scotia has no set definition of core. Members agreed to adopt Alberta's definition of core, which is "those services that will be delivered or accessible (available) at the community, regional and provincial level to every Nova Scotian who needs them."

Accessible is defined as "if the service is not provided within a region, it will be available provincially...not every service will be provided in every community."

M. MacIsaac suggested having two sections in the recommendations, one section on services traditionally funded by the Department of Health, and a section on determinants of health, which would integrate other departments and sectors.

4. November 25-26 Advisory Committee

Core Services Document - Draft 1

N. Mensink and W. Marsh will put together an information package for members of the advisory committee by October 18th. The package should be sent out at least two weeks before the session begins.

The steering committee will compile feedback from advisory committee members on the information package to form a draft document for the November 25-26 session. The document would outline what members felt core services should consist of.

Public Consultation

Public consultations will be held in co-ordination with Community Health Boards. B. Hart and J. Dow will attend as many of the estimated 18 open process consultations as possible, as representatives of the Provincial Health Council.

Advertising for the public consultations will be done with the assistance of Community Health Boards.

A 1-800 phone line will be hooked up to an answering machine for comments coming in from the public. The phone line will be included in ads for public consultations.

The general public can also send their comments through the Provincial Health Council web site and e-mail.

The draft document will be put into a workbook format and will be distributed at public consultations for comments.

5. Work Plan and Time Line

Please see the attached pages for the work plan and time line for the development of the core services document.

CORE SERVICES COMMITTEE
Work Plan and Time Line

Oct 1999	- Get in touch with Council of Chairs (Tom & Barb)
by Nov 11, 1999	- consult with Wayne Marsh re meeting - formalise process for Advisory Committee meeting
Nov 11, 1999	- request Advisory Committee to submit recommendations around Core Services for inclusion in DRAFT 1
Nov 22, 1999	- DRAFT 1 recommendations in from Advisory Committee as working document for the 2 day workshop
Nov 25/26, 1999	- Advisory Committee Meeting - 2 day retreat - Possible formats suggested so far: a) groups around programme areas at three levels b) groups around community, regional / provincial levels of service - how best to accomplish result - a / b / combination of a & b / any other ideas - draft process on Monday am and meet with Wayne on pm
Dec 17, 1999	- DRAFT 2, put into workbooks for Public Consultation
Jan 3 to Mar 3, 2000	- Public Consultation, - Town Hall Meetings - Want open process. - Community Health Boards to be the inviters and co-ordinators in public consultations, i.e., open invitations for everyone. - A prescribed process for meetings to be developed. - Phone line - could hook up a phone line to an answering machine for comments that come in from the public. Decided to use 1-800 number and place this in ads inviting participants in town hall meeting. - Web site and e-mail to get input from the general public. Draft to be put on web site with invitation to respond. - Work book format of draft document to present to the public for comments.
Jan 3 to Jan 24 weeks	- Western Region CHBs (Kings, Annapolis, Digby, Yarmouth, Shelburne, Queens, Lunenburg)
Jan 24 week	- Central Region (Halifax, West Hants)
Jan 31 to Feb 7 weeks	- Northern Region (Cumberland, Pictou, Colchester & East Hants)

Feb 14 to Feb 28 weeks	- Eastern Region (Cape Breton, Victoria, Inverness, Richmond, Antigonish, Guysborough)
Mar 17, 2000	- DRAFT 3, incorporating feedback and input from public consultation - provide to RHB, NDO, & DoH participants for further feedback from their stakeholders by Mar 31, 2000
Mar 31, 2000	- receive feedback from RHB, NDO, DoH and prepare DRAFT 4 for Advisory Committee meeting
Apr 7, 2000	- Advisory Committee Meets to consider further input based on the public consultation results
Apr 21, 2000	- DRAFT 5 to go to Council for final approval
May 4, 2000	- Council meets to review DRAFT 5
May 26, 2000	- submit FINAL DOCUMENT to Government through Minister

Core Services Committee
12 Oct 1999

Provincial Health Council
Core Services Committee
October 18, 1999
9:30 a.m. - 3:30 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), N. Mensink, M. MacDonald, W. Marsh, B. Hart (Ex-Officio), J. Dow (Ex-Officio)

1. Matrix

B. Hart stated the not-for-profit organizations (now called NGO's, or non-government organizations) still are not included in the matrix. Committee members agreed to include two NGO representatives.

J. Dow circulated a copy of the matrix that including check marks beside the names of the people who have agreed to attend the session.

T. Bird requested that the positions of everyone listed in the matrix be added for the next meeting.

2. Core Services 1-800 Phone Line

The Provincial Health Council has a 1-800 phone line that rings at the switchboard. Suggestions for a phone line for the core services committee included getting a second 1-800 number and hooking it up to an answering machine at another desk at the PHC office. Messages could be checked daily.

3. Public Consultations

Advertising ideas for public consultations include public service announcements, placing ads in the provincial daily newspapers and asking community health boards for assistance. J. Dow and L. Scallion Morine will draft a poster for the community health boards to distribute throughout their communities.

Chairpersons for the consultations could be selected by community health boards, although they would have to be approved by the core service committee.

J. Dow offered to record and project key points during the consultations using a lap top computer and projector. The consultations would also be mechanically recorded.

Community health boards could locate facilities for the consultations. They will be instructed to choose free facilities. If none are available, the committee will pay a maximum of $100 for each facility.

Community health boards will be informed of the committee's mandate, time schedule and process for consultations. They will also be supplied with a workbook and posters, a copy of Nova Scotia's health goals and the PHC brochure.

A list for attendees to sign their names will be provided at consultations.

T. Bird, B. Hart and J. Dow will meet with the Council of Chairs for the community health boards.

4. Process

W. Marsh stated that a good list of core services will be drafted when:

- it addresses the matter of access to services
- it facilitates a common understanding of what the public and other stakeholders can expect
- it provides a basis for determining service standards
- the potential for affecting the demand of core services can be linked to determinants of health (i.e., implementing public policy levers)

T. Bird stated that the advisory committee should be aware that the draft document they create may change after public consultations.

W. Marsh suggested distributing a draft document to advisory committee members before the session. This document would include the results of a questionnaire sent to them and research information.

W. Marsh suggested spending the first part of day one putting together a definition of terms and discussingj health goals and determinants of health. Members would then discuss services at the community level. Regional and provincial services would be discussed on day two, and then overall conclusions would be formed.

A combination of a large group and smaller groups could be used. Each small group would be led by a facilitator and would have a timer and recorder.

Provincial Health Council
Core Services Committee
October 25, 1999
9:30 a.m. - 12:00 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, N. Mensink, B. Hart (Ex-Officio), J. Dow (Ex-Officio)

1. Regional Health Boards

The changes made by the Government of Nova Scotia to the Regional Health Boards will not affect their participation in the Advisory Committee.

2. Core Services 1-800 Phone Line

J. Dow stated that it would cost $15 to add a second 1-800 line. MT&T can set up a special answering service which would allow callers to leave their comments and fill out a questionnaire electronically. The first 150 minutes each month would be free, and each minute after that would be $.20. There is no other monthly charge. MT&T could hook up the number within 24 hours. Staff would listen to and record the comments daily.

N. Mensink suggested doing a trial run of the electronic questionnaire once it's set up to see how long it would take to be completed.

3. Matrix

Representatives from NGO's and minority groups were suggested. Committee members have received some acceptances to invitations but there are still other invitations which are outstanding.

J. Dow will add the positions of everyone invited once all acceptances have been received.

4. Community Health Boards

T. Bird, B. Hart and J. Dow will attend the Northern Regional Council of Chairs meeting on November 8th at 4:30 p.m. in Truro to discuss the role of the Community Health Boards in public consultations on core services and the Provincial Health Council. A meeting of the Central Regional Council of Chairs is tentatively set for November 18th.

5. Poster

N. Mensink suggested changing the word "comment" to "leave your opinion." Once the 1-800 phone number has been set up, the posters will be printed in-house and sent to the Community Health Boards.

6. Information Package

N. Mensink stated the recommendations are based on four things:

1. Principles and guidelines in health goals
2. Community input
3. Principles and guidelines from other jurisdictions
4. The major health issues in Nova Scotia that should be addressed in core services.

Committee members agreed to limit the information sent to advisory group members to 20 pages. Epi Map can be used to create graphic representations of data.

N. Mensink suggested changing the phrase "context of work" on the first page of the draft agenda to " set of criteria for core services." She also suggested adding "principles developed elsewhere" as a third point under "context."

J. Dow and N. Mensink will contact the NSAHO to request volunteer facilitators for the small group discussions.

W. Marsh provided the committee with a facilitator guide. N. Mensink suggested changing the word in #4 on the first page, from "non-provider" to "health services user." Under the next point, "and broad determinants of health" should be added.

N. Mensink suggested asking Community Health Board representatives before the session to be discussion starters during community health discussions.

7. Tasks for Next Meeting

N. Mensink will create a draft package for next meeting.

J. Dow and L. Scallion Morine will develop a communication plan for next meeting.

J. Dow will add core services information to the Provincial Health Council web site and e-mail that information to T. Bird.

W. Marsh will attend next meeting at 1:00-1:30 p.m.

Provincial Health Council
Core Services Committee
November 1, 1999
9:30-3:30 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, N. Mensink, M. MacIsaac, W. March, B. Hart (Ex-Officio), J. Dow (Ex-Officio)

1. Calendar for Public Consultations

In the Western Region, a public consultation will be set up in Lunenburg County and Queens County the week of January 3rd. On the week of January 10th, consultations will be set up in Shelburne and Yarmouth Counties. The Community Health Boards will set up the consultations where they feel they are appropriate.

Consultations will be set up in Kings and Hants Counties the week of January 24th, and in Halifax and Colchester Counties the week of January 31st. The Central Region should have four consultations because it has a large population. Colchester County and Cumberland County's consultation will be held the week of February 7th and Pictou County's consultation will be held the week of February 14th. Consultations will be held for Inverness and Victoria Counties the week of February 21st, and for Cape Breton and Richmond Counties the week of February 28th.

2. Meeting Dates with Community Health Boards

J. Dow, B. Hart and T. Bird will meet with the Northern Regional Council of Chairs on November 8th in Truro. The Western Region meeting is scheduled for November 13th in Cornwallis. T. Bird and M. MacDonald will meet with the Central Region Council of Chairs on November 18th at the Nova Scotia Hospital, and J. Dow and B. Hart will meet with the Eastern Region on November 18th in Baddeck.

3. Information Package

N. Mensink put together an information package to be sent to the Advisory Committee members on November 5th. The package includes an introductory page which details the committee's history, what the process will be based on, who is on the committee and what's contained in the package. The package outlines core services offered by Canadian provinces and the frame work for Health 21. M. MacIsaac will revise the list of core services in Nova Scotia.

N. Mensink drafted a list of questions to be sent with the package. Members are asked to send their answers by November 22nd. The package will also include an agenda for the session and an explanation of expenses covered.

4. Definition of Community

Community is defined by Webster's Dictionary as "a body of people living near one another and in a special relationship." The committee felt this is an adequate definition.

5. Communications

L. Scallion Morine presented ideas on advertising public consultations, including having the Community Health Boards advertise, circulating posters, and having news articles in newspapers, on the radio and on tv. A time line needs to be developed for advertising. Committee members felt that advertising for Core Services should quickly follow advertising for the Provincial Health Council.

Public Service Announcements must be sent out by the first week in December. A press release should be sent out by the middle of November.

Public Consultation dates could be included in church bulletins and lists of community events in newspapers, on television and on the radio. Notices could also be distributed to students.

For the next meeting, J. Dow and L. Scallion Morine will prepare draft press releases and time lines.

6. Workbooks

Workbooks for public consultations will be prepared by December 17th and will be sent to Community Health Boards by December 20th. Workbooks will be couriered to the Western Region.

Provincial Health Council
Core Services Committee
November 8, 1999
12:00 p.m. - 2:00 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacIsaac, B. Hart (Ex-Officio), J. Dow (Ex-Officio)

1. Information Package

Information packages were sent to participants around the province on November 5th and to provincial employee participants through interdepartmental mail on November 8th.

M. MacIsaac provided a piece on core services in Nova Scotia, which will be sent to participants promptly.

2. Communications

B. Hart stated that the Seniors' Secretariat offered to send notices to its members regarding public consultations.

The Provincial Health Council raised concerns that the phrases "core health services" and "public consultations" on the poster would be confusing for the general public. Core Services Committee members changed those phrases to "health services" and "public meetings." The line "concerned about health care" was changed to "we need your views about health services," and "if you cannot attend the meeting" was added to the contact information.

J. Dow and L. Scallion Morine developed a communications time line. B. Hart felt a press release including the accomplishments of the Provincial Health Council, information on the November session and information on public consultations should be sent out immediately after the press kits are released.

Council members are asked to contact their local newspapers if press releases aren't run. Council members could answer media questions or refer them on B. Hart.

3. Meeting with Deputy Minister of Health

B. Hart, T. Bird and J. Dow will meet with the Deputy Minister of Health at a stakeholders' meeting on November 17th, to discuss time lines for the core services review.

4. November 25-26 Session

M. MacIsaac suggested outlining the process to participants before the retreat to eliminate confusion.

Provincial Health Council
Core Services Committee
November 22, 1999
9:30 a.m. - 12:30 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, N. Mensink, J. Dow

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1. Meetings with Community Health Boards

T. Bird, J. Dow and B. Hart attended the Northern Region's Council of Chairs meeting in Truro on November 8th. The meeting went well.

J. Dow and B. Hart attended the Western Region's Council of Chairs meeting on November 13th in Cornwallis. This region seemed to have the greatest amount of interest in the Provincial Health Council.

M. MacDonald and T. Bird attended the Central Region's Council of Chairs meeting on November 18th in Dartmouth. Members of this region had numerous questions and expressed concerns about the public consultation process. They felt that the consultations would not be successful due to the time of year they were being held, and because it is difficult to generate interest with the general public. Members offered no alternatives on the best way to obtain public responses, although they advised the committee to deliver as much information to the public before the consultations as possible.

J. Dow and B. Hart attended the Eastern Region's Council of Chairs meeting on November 18th in Baddeck.

N. Mensink suggested developing an information package to distribute to the Community Health Boards before the public consultations, to give them a better understanding of what the committee is seeking from the public. This package would be sent before or with the workbooks.

The workbooks will be completed by December 9th, for review by the committee. They will be sent to the Community Health Boards on December 15th.

2. Communications

L. Scallion Morine prepared a press release and sent it to Communications Nova Scotia on November 19th. The Cape Breton Post ran a story on the release on November 22nd. A second press release will be issued on December 6th. Press releases will be distributed by

Communications Nova Scotia, and a copy of the releases will be forwarded to the Communications office at the Department of Health.

Ads for public consultations will be run in The Daily News, The Cape Breton Post and The Chronicle Herald. Canon Sid Davies will interview B. Hart for Access Cable in New Minas and other cable stations in Nova Scotia. L. Scallion Morine will contact *First Edition* and *Live at Five* to set up interviews with B. Hart. She will also obtain ad prices from The Coffee News and flyer packs, as well as contact university newspapers for articles.

3. Advisory Committee

Every member for the Advisory Committee has been identified except one person from the Department of Justice. N. Mensink distributed an information package to be given to members at the two-day session, as well as additional information for the steering committee. She will also create a matrix from responses to the questionnaire, for distribution at the session.

4. Public Consultations

T. Bird stated that the Deputy Minister wants to shorten the completion time of the review of core services, requiring a draft document by March 15th. Public consultations will have to conclude at the end of February. N. Mensink and the council researcher will begin preparing the document after the first consultation. The Deputy Minister guaranteed the committee more help, if required, to complete the project.

M. MacDonald and J. Dow will hold consultations in Cape Breton, and N. Mensink and B. Hart will hold consultations in Comberland, Colchester and Pictou Counties.

The Advisory Committee will review the document before the council meets to review it, a week before it is delivered to the Minister of Health.

Provincial Health Council
Core Services Committee
December 3, 1999
1:30 - 3:30 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, N. Mensink, J. Dow, B. Hart

1. Advisory Committee

N. Mensink drafted a report from information provided by facilitators at the Advisory Committee meeting on November 25 and 26. She received verification from the facilitators, who are satisfied with the report. N. Mensink stated that the report provided a set of criteria for the Core Services Committee to use.

2. Workbook

N. Mensink stated that the workbook should be easy to use, and that its basic principles be the health goals and determinants of health. She suggested listing the health goals on the top of each page that relates to principles and services. The introduction is one of the most important pieces, as it will either attract or not attract the reader's interest. Members felt demographic questions, including age, gender, county and community should be included.

N. Mensink outlined the contents of the workbook, which will include the health goals and determinants, an introduction, and a summary of the community health plan. Respondents would be asked to rank the importance of the principles, and would be asked about services. The questions would cover approximately five pages, with two or three pages of information.

3. Delivery of Workbooks

Workbooks will be couriered to the Western Region. They will be sent to anyone who requests copies. B. Hart stated that the Senior Citizen's Secretariat will notify their members about the public consultations and should have copies of the workbook. Not for profit organizations will also assist in distributing copies. Members suggested distributing workbooks to the Teachers' Union, school advisory councils, school board associations, legions, professional organizations, hospitals and MLA's.

4. **Return of Workbooks**

J. Dow suggested including stamped envelopes witn workbooks for people to mail to the Provincial Health Council. The council would only be billed for postage of envelopes mailed back.

5. **Responses from Community Health Boards**

- J. Dow listed the following dates for public consultations:

Jan. 10 - Queens County
Jan. 12 - Shelburne County
Jan. 13 - Yarmouth County
Jan. 17 - Lunenburg
Jan. 18 - Annapolis
Jan. 27 - East Hants County
Feb. 17 - Guysborough County

Provincial Health Council
Core Services Committee
December 9, 1999
9:30 a.m. - 3:00 p.m.

Suite 301, 1888 Brunswick Street

Present: T. Bird (Chair), N. Mensink, M. MacIsaac, M. MacDonald, B. Hart, J. Dow

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Workbook

Members discussed both the content and structure of the workbook. N. Mensink presented two workbooks, one developed with the health goals and determinants of health, and one focusing on specific core clinical services.

The first workbook contained a brief introduction, listed the health goals, and listed the determinants of health with a brief description of each determinant in layman's terms. She summarized core services in a matrix, with descriptions or examples. The final page contained questions suggested by the Advisory Committee.

The second workbook focused on core clinical services. She suggested that if this workbook is used, it would require detailed definitions of terms and more room for comment. This document could incorporate lists of core clinical services obtained from the Advisory Committee, Community Health Plans and the work done in regions.

Members discussed different options, including producing two or three workbooks, one of which would be produced by the Department of Health. They decided that the document(s) would be perceived by the public as being produced by the Provincial Health Council, so the document(s) should be solely the work of the council.

The final decision involved one workbook which would be divided into two parts. The first part would contain information from the first workbook N. Mensink presented, which focused on the health goals and determinants of health. The second section would be optional for the public to complete and would focus on core clinical services. This second section would contain a brief description of each service and pages for comments. It would have a grey tab along its side or would be printed on coloured paper to separate it from the rest of the document. The introduction would contain the council's mission, vision and role, as well as the mandate of the Core Services Committee.

The workbook will be sent to print on December 13th.

The report presented to government on core services would contain information gathered from other provinces on core services, work done in Nova Scotia by the Department of Health and the Regional Health Boards, work done by the Community Health Boards, recommendations from the Advisory Committee and responses from public consultations.

Provincial Health Council
Core Services Committee
December 20, 1999
9:30 a.m. - 1:30 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, N. Mensink, B. Hart, J. Dow

Workbook

J. Dow translated the workbook using translation software, then sent it to two Francaphone editors. One editor felt more work was required, as themes and issues were not clearly translated, so the workbook was forwarded to St. Anne University. The workbook will be ready to send to print by December 29th.

One thousand workbooks were received and will be forwarded to the Western Region.

Consultation Process

Committee members reviewed the consultation process in terms of what they want to convey to the public and what they would like to receive. B. Hart stated that public meetings are an opportunity to let the public know about the Council, what it's doing, and its vision, as well as its mandate with core services.

The committee will focus discussion on Nova Scotians living healthier lifestyles, as well.

N. Mensink suggested putting paper on the walls during the meetings, to record the public's suggestions on what they can do for their health, and what services they need for that. They could also record people's agendas for what they would like to discuss at the meetings.

Members felt it is important to let the public know that the Council isn't from the Department of Health, but rather it is composed of average Nova Scotians, who feel the public's views are important and will bring those views to government.

J. Dow and N. Mensink will create a mediator's guide, so all public meetings will be conducted similarly. B. Hart, J. Dow, N. Mensink, M. MacDonald and B. Anderson will mediate the meetings.

Collating Information

N. Mensink will create a template and fill in information as it comes in from public meetings. Using Microsoft Access or Excel, information can be coded and arranged according to demographics.

A report will be given to government in mid-March, although the final report will not be given until May. The first report will be created in-house. The advisory committee will meet on April 7.

Telephone Survey

The telephone survey will incorporate the determinants of health questions, what we believe about health for Nova Scotians questions, other questions and demography questions, as well as an opportunity for comments.

The complete workbook will be posted on the Council's web site.

Advertising

Communications Nova Scotia drafted an advertising estimate, which is around $10,000. Advertising includes a large ad in The Chronicle Herald, The Daily News and The Cape Breton Post, listing all the meetings for January and February. Smaller ads will be placed in weekly newspapers, advertising the meeting for their area.

Provincial Health Council
Core Services Committee
January 5, 2000
11:30 a.m. - 12:30 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, N. Mensink, B. Hart, J. Dow

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N. Mensink discussed facilitation of public meetings and distributed a facilitator's guide. She suggested the recorder write down statements in the words of the speaker. A flip chart can be used for taking notes, and the charts posted on a wall. Banners for health and services, and for community, region and province can be created before the meeting. It's important for the public to indicate at which level they feel services should be offered. Definitions of community and region will be developed for facilitators, as well as answers to questions the public may ask.

Members discussed how to deal with complaints they may receive about health services. They decided to re-affirm their purpose for the meeting to steer discussion back on the right topic.

N. Mensink will develop a Plan B for meetings of over 15 people. This plan will consist of dividing the group into small discussion groups.

The Department of Health does not have the technology to set up interactive web sites, so people will have to download the workbook from the council web site to complete it.

Provincial Health Council
Core Services Committee
June 7, 2000
11:00 a.m. - 3:00 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, N. Mensink, B. Hart, J. Dow

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The committee discussed the June 5th meeting of the Advisory Committee, which members felt was successful and productive. They reviewed a document containing information gathered at that meeting.

The document contained four sets of recommendations. The Core Services Committee members compiled these recommendations into one list, which will be presented at the Provincial Health Council meeting on June 8th.

The committee discussed the final report and decided that it should be outcome focused, and based on the health goals and determinants of health.

J. Dow and N. Mensink will prepare a matrix that will contain global comments stated by Nova Scotians in the workbooks and during public consultations.

Council will meet on June 23rd to review the final core services document.

The next Core Services Committee meeting will be held on June 15th at 9:30 a.m.

Provincial Health Council
Core Services Committee
June 15, 2000
10:30 a.m. - 2:30 p.m.

Suite 301, 1888 Brunswick Street, Halifax, NS

Present: T. Bird (Chair), M. MacDonald, N. Mensink, B. Hart, J. Dow

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N. Mensink presented the document she and J. Dow created, which listed recommendations for the core services report.

N. Mensink explained that the first set of bullets on the first page contain content pieces, and the second set of bullets contain process pieces. The document contained language from the source document to make it more complete.

T. Bird felt the document should utilize the language used by Nova Scotians. The committee also discussed whether or not the language should change when the document is submitted to government.

The committee reviewed the recommendations and made changes. Members discussed placing responsibility for implementing the recommendations, and whether or not it was the role of the committee to decide who should be responsible. They discussed bringing the matter to council to decide.

The committee also discussed whether the document should be broad, or if it should contain specific recommendations made by the public, such as introducing nurse practitioners, youth centres and community health centres. T. Bird suggested providing council with information from the public and deciding the focus during the June 23rd meeting.

N. Mensink suggested developing a list of questions for council members to answer prior to the June 23rd meeting. She will draft a process plan for the meeting, and J. Dow will draw up an agenda.

Provincial
Health Council

Core
Services
Public
Consultation

Advisory Committee

Background Reading
Material

November 25 & 26, 1999

DRAFT

Suite 301
1888 Brunswick Street
Halifax, NS
B3J 3P7

Introduction

The Government of Nova Scotia has given a mandate to the Provincial Health Council to recommend a range of core health services at the community, regional and provincial levels. For purposes of this work, "core health services" is defined as those services that will be delivered or accessible (available) at the community, regional and provincial level to every Nova Scotian who needs them. You have been invited to be part of an Advisory Committee which will provide input and expertise to the Provincial Health Council steering committee on the development of a draft document which identifies core services for Nova Scotians.

The steering committee of the PHC, which is working on this mandate, has determined to approach the task by basing our recommendations on the Nova Scotia Health Goals (reaffirmed by the Government of Nova Scotia on November 3, 1999) and by taking into account the following:

- the broad determinants of health
- consultation with the public across Nova Scotia
- principles and guidelines developed elsewhere in Canada and in the world
- major health issues that face Nova Scotians.

The **Advisory Committee** includes representatives of:

- the four major referral hospitals in the province (sometimes called the NDOs or non-designated organizations),
- the four Regional Health Boards
- eight of the Community Health Boards
- the Department of Health and several other departments (Justice, Environment, Education, Community Services)
- key professional interest groups
- other key stakeholders

In this package of pre-meeting reading materials, you will find some notes on a conceptual framework for the task based on the Nova Scotia Health Goals, and a summary of what we have found to date on the principles and guidelines developed elsewhere in Canada and the world.

DRAFT

Conceptual Framework

The Provincial Health Council approaches the current task of identifying core health services from the perspective of **Nova Scotia's Health Goals**:

> Health is the capacity to function optimally and to achieve well-being.
>
> We believe that all Nova Scotians can achieve health.
>
> We believe that the health of individuals and communities has many aspects, including emotional, physical, social and spiritual well-being.
>
> We see the health of our people as a resource for the present and the future. Each of us has a role to play to protect and develop that resource. Education, particularly of our children and youth, is very important.
>
> We believe our health care system must be publicly administered, comprehensive, universal, portable and accessible to all Nova Scotians. Public administration must include public participation and accountability.

Together, as individuals and members of groups and communities, and with all government departments, we commit ourselves to these health goals:

> *Health Promotion:* Promote and improve the health of all Nova Scotians.
> *Healthy Environment:* Make Nova Scotia a safe and healthy place to live.
> *Management:* Ensure that the resources needed to support health are managed wisely and fairly.
> *Participation:* Involve Nova Scotians in decisions affecting health.
> *Social Justice:* Ensure that all Nova Scotians have the opportunity to achieve health.

Determinants of Health

Health Canada in the document Taking Action on Population Health states that "there is strong evidence indicating that factors outside the health care system significantly affect health." These "determinants of health" include:

- income and social status
- social support networks
- education
- employment and working conditions
- physical environments
- social environments
- biology and genetic endowment
- personal health practices and coping skills
- healthy child development
- health services
- gender
- culture

A useful definition of **community**: a body of people living near one another and in a social relationship.

Principles Related to Provision of Health Services Identified in Other Jurisdictions

◆ Begin with the person in community.

- This is identified in Europe in the Healthy Cities projects where communities of about 200 hundred persons formed the base starting point for improvement of health and healthy living conditions in many northern European cities.
- Article 129 of the Maastricht Treaty on European Union (on Public Health) says partly that "the Community shall contribute towards ensuring a high level of human health protection by... (taking) action towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education."
- In Britain, health services are organized around District Health Authorities (focused on communities) with merged "practice authorities" who regulate and pay local physicians and a body similar to our Community Health Boards.
- In Finland, after decentralization of their health system, variation appeared between jurisdictions on policy priorities. Increased autonomy and economic scarcity have forced local decision-makers to determine priorities and evaluate results.

◆ Use of a consumer-oriented approach that encourages personal responsibility and awareness (primarily within some form of socialized health care).

- Assess the health needs of populations.
- Promote equity of opportunity for health and health services with focused attention on the poor or disadvantaged.
- Focus attention on health challenges in order to improve population health status.
- Promote and use intersectoral partnering.
- Work on social issues that affect determinants of health:
    - redistribution of income
    - improvement of living conditions
    - improvement of working conditions
    - increase employment
    - reduce pollution
    - improve access to health services at local levels

◆ Recommended formulae for funding (of health services) in North America:

- emphasize identification of needs based on population age and gender, and on local issues (identified in community using principles for funding based on needs identification that include: validity, acceptability, resistance to manipulation, flexibility, avoidance of perverse incentives, feasibility)
- emphasize generic formulae, not program specific ones

◆ In the USA and Canada, a principle which is either applied without question or is hotly debated (especially in rigidly administered managed care plans in the US) is the principle of choice of care providers.

- In an American survey (Oregon) conducted to determine values of the public in health care, the following were identified:
    - local access to health care was the most important health policy issue (local access, affordable services, coverage for everyone)
    - health care must have a human face, with adequate time and communicate with direct care givers (especially physicians)
    - involvement of citizens in the development of health policy, and in improvement and changes in the system

Note: These principles are derived from the following sources:

1. *World Health Organization Documents*
2. *Eurohealth (a journal of the European Union)*
3. *Internet documents describing the health services of various Canadian provinces and American states.*

Health 21

The Health for All Policy Framework for the WHO European Region (1999)

This document, created from the principles developed through WHO at various world conferences on health, articulates some relevant principles and approaches that can help us in our identification of core services for Nova Scotians.

> "The European Region of WHO now has almost 15 years of experience in together designing, implementing, monitoring and evaluating a joint outcome-focused, targeted and innovative policy in health that integrates efforts to promote healthy lifestyles, a healthy environment, and quality-oriented and cost-effective health care." (Page 2)

- The key learning points here are:

- joint — working together among a variety of countries with widely varying histories and approaches to self-governance
- outcome-focused — establishing the desired outcomes and targets, and leaving the details up to the individual states and communities
- the focus on lifestyles and a healthy environment are reflective of our health goals

According to the document, "Health for All" is becoming "a broad societal movement through the creation of collaborative networks...[which act as] vehicles to mobilize many sectors and organizations to work together in permanently organized partnerships of regions, cities, schools, work sites, health institutions and professionals, non-governmental organizations, etc., that join forces to make the HFA idea a reality in their individual areas..." (Page 3).

Two main aims:

- promoting and protecting people's health throughout the course of their lives;
- reducing the incidence of and suffering from the main diseases and injuries.

Three basic values:

- health is a fundamental human right;
- equity in health and solidarity in action between [all parties];
- participation by and accountability of individuals, groups and communities, and of institutions, organizations and sectors in health development.

Four main strategies for action:

- multi-sectoral strategies to tackle the determinants of health, taking into account physical, economic, social, cultural and gender perspectives, and ensuring the use of **health impact assessments**;
- health-outcome-driven programs, and investments for health development and clinical care;
- integrated family- and community-oriented primary health care, supported by a flexible and responsive hospital system; and
- a participatory health development process that involves relevant partners for health, at all levels - home, school and work site, local community and country - and that promotes joint decision-making, implementation and accountability.

Targets for the 21st Century

1. **Solidarity for Health in European Region:** by the year 2020, the present gap in health status between member states of the European Region should be reduced by at least one third.

2. **Equity in Health:** by the year 2020, the health gap between socio-economic groups within countries should be reduced by at least one fourth in all member states, by substantially improving the level of health of disadvantages groups.

3. **Healthy Start in Life:** by the year 2020, all newborn babies, infants and pre-school children in the region should have better health, ensuring a healthy start in life.

4. **Health of Young People:** by the year 2020, young people in the region should be healthier and better able to fulfil their roles in society.

5. **Healthy Aging:** by the year 2020, people over 65 years should have the opportunity to enjoy their full health potential and play an active social role.

6. **Improving Mental Health:** by the year 2020, people's psycho-social well-being should be improved, and better comprehensive services should be available to and accessible by people with metal health problems.

7. **Reducing Communicable Diseases:** by the year 2020, the adverse health effects of communicable diseases should be substantially diminished through systematically applied programs to eradicate, eliminate or control infectious diseases of public health importance (poliomyelitis, neonatal tetanus, indigenous measles, etc)

8. **Reducing Noncommunicable Diseases:** by the year 2020, morbidity, disability and premature mortality due to major chronic diseases should be reduced to the lowest feasible levels throughout the region (cardiovascular diseases, cancers, diabetes-related health effects, chronic respiratory diseases, etc.).

9. **Reducing Injury from Violence and Accidents:** by the year 2020, there should be a significant and sustainable decrease in injuries, disability and death arising from accidents and violence in the region.

10. **A Healthy and Safe Physical Environment:** by the year 2015, people in the region should live in a safer physical environment, with exposure to hazardous contaminants at levels not exceeding internationally agreed standards.

11. **Healthier Living:** by the year 2015, people throughout society should have adopted healthier patterns of living.

12. **Reducing Harm from Alcohol, Drugs and Tobacco:** by the year 2015, adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psycho-active drugs should be significantly reduced in all member states.

13. **Settings for Health:** by the year 2015, people in the region should have greater opportunities to live in healthy physical and social environments at home, at school, at the workplace and in the local community.

14. **Multi-sectoral Responsibility for Health:** by the year 2020, all sectors should have recognized and accepted their responsibilities for health.

15. **An Integrated Health Sector:** by the year 2010, people in the region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system.

16. **Managing for Quality of Care:** by the year 2010, member states should ensure that the management of the health sector, from population-based health programs to individual patient care at the clinical level, is oriented toward health outcomes.

17. **Funding Health Services and Allocating Resources:** by the year 2010, member states should have sustainable financing and resource allocation mechanisms for health care systems based on the principles of equal access, cost-effectiveness, solidarity and optimum quality.

18. **Developing Human Resources for Health:** by the year 2010, all member states should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health.

19. **Research and Knowledge for Health:** by the year 2005, all members states should have health research, information and communication systems that better support the acquisition, effective utilization and dissemination of knowledge to support health for all.

20. **Mobilizing Partners for Health:** by the year 2005, implementation of policies on health for all should engage individuals, groups and organizations throughout the public and private sectors, and civil society, in alliances and partnerships for health.

21. **Policies and Strategies for Health for All:** by the year 2010, all member states should have and be implementing policies for health for all at federal, regional and local levels, supported by appropriate institutional infrastructures, managerial processes and innovative leadership.

Summary Table of Core Health Services Identified by Canadian Provinces

Service/Province	BC	AB	SA	MA	NB	NS	PEI
Community Health Assessment	✔	✔	✔	✔	✔		✔
Health Promotion	✔	✔	✔	✔	?	✔	✔
Health Protection	✔	✔	✔	✔	?	✔	✔
Prevention and Public Health Services	✔	✔	✔	✔	✔	✔	✔
Community Acute and Chronic Care		✔	?	✔	✔		✔
Regional Acute and Chronic Care	✔	✔	✔	✔	✔	✔	✔
Tertiary Acute Care	✔	✔*	?	?	?	✔	✔**
Developmental, Rehabilitation and Support	✔	✔	✔	✔	✔	✔	✔**
Palliative Care	✔	✔	✔	✔	?	✔	✔**
Home Based Care	✔	✔	✔	✔	✔	✔	✔
Residential Care (Long-Term Care)	✔	✔	✔	✔	?	✔	✔
Mental Health Services	✔	✔	✔	✔	✔	✔	✔†
Substance Misuse Services	✔	?	✔	✔	?	✔	✔†

* Regional
** In one region only
† In some regions
? Information not available

Details of Core Services Across Canada

British Columbia

Identifies core services as very "general categories of service which must be covered off in a *Regional Health and Management Plan*" (page i, Inventory of Existing Health Services, Government of British Columbia, February 1995). Core services list released in July 1994.

Community Health Assessment
Health Promotion
Health Protection
- Mandated environmental health protection services
- Community care facilities licensing and support
- Communicable disease control

Prevention and Public Health Services
- Prevention of injury, non-communicable disease and substance misuse
- Wellness
- School health
- Reproductive health
- Dental health
- Nutrition
- Hearing
- Speech/language

Treatment (acute and chronic care)
Developmental, Rehabilitation and Support
- Rehabilitation therapy
- Early childhood intervention

Palliative Care
Home-Based Care
- Home support and other support services
- Clinical care
- Respite
- Care coordination

Residential Care
- Residential care options
- Residential care for special populations

Mental Health Services
- Clinical services
- Support, psycho-social rehabilitation and outreach
- Emergency response and short term intervention

Substance Misuse Services
- Detoxification
- Treatment
- Support

Work done since core services identified: regions identified programs provided and related them to each of the core services (1995).

Alberta

"Core health services refer to those health services which must be available or reasonably accessible to every person who needs them. *Available* means the service is provided within each region. *Accessible* means if the service is not provided within a region, it will be available from another region or through a program that serves the whole province...Not every service will be provided in every community" (Page 2).

Services (Regional Responsibility for Core Health Services)

Promotion of health and prevention of illness and injury

- Birth and parenting services
- Suicide prevention
- Family health
- Nutritional health
- Oral health
- Sexual and reproductive health
- School health
- Prevention of chronic disease
- Screening and counseling for hereditary diseases

Protection of Health

- Control of communicable disease
  - screening and selective testing
  - immunization
  - treatment for infectious disease
- Protection from environmental health hazards
  - monitoring
  - assessment
  - inspection
  - data collection
  - hazard analysis
  - public education
  - consultation
  - enforcement

Community Care and Support

- Case co-ordination
  - information and referral
  - assessment
  - service planning
- Personal supports
  - professional health services
  - rehabilitation services
  - personal care
  - home support
  - respite services
    (support arrangements for families and caregivers)
  - palliative care services
  - assessment and authorization of technical supports

Residential Long-Term Care Services
Acute Care Services

- Primary level acute care services
  - obstetrical
  - prenatal
  - paediatric
  - geriatric
  - mental health
  - pharmaceutical
  - medical surgical
  - rehabilitative
  - palliative care
- Secondary level acute care services
  (More complex diagnostic and treatment services delivered by providers with specialist training)
- Tertiary level acute care services
  (Sophisticated diagnostic and highly specialized treatment services provided on referral from physicians and other health professionals)
- Emergency services
  - 24-hour acute care hospital resources
  - transfer between facilities
  - co-ordination with both ground and provincial air ambulance services

Provincial Core Services

Cancer Services
Mental Health Services

- Public education
- Assessment
- Self-help and mutual aid
- Crisis intervention
- Short- and long-term interventions
- Assistance in accessing housing and income support
- Forensic services
- Continuing care for individuals who cannot be support in community settings

Physician and Allied Health Care Provider Services
Aids to Daily Living Program
Air Ambulance Service
Cleft Palate Program
Provincial Laboratories for Public Health
Communicable Disease Monitoring
Co-ordination of Specialized Treatment for Tuberculosis and Sexually Transmitted Diseases

Saskatchewan

- Based on Principles of Wellness
- Outlines services to be provided by District Health Boards

Planning and Coordination

-District Boards must:

- Develop a health plan
- Establish clear lines of communication with other agencies that affect health (wellness)
- Have emergency transportation

Healthy Public Policy

- District Boards to be involved in the development of health public policy for the district

Services

- Must be available or accessible to residents in each district
- Interdisciplinary
- Based on condition of the whole person and the environment
- Can include partnering with other agencies affecting health

Assessment and Case Management
Education and Health Promotion
Consumer Inquiry
Home Base Services

- Helps for daily living or nursing care to maintain independence
- May be at dwelling, work site or school
- Includes support for informal caregivers
- Acute palliative and supportive care

Respite Care

- Based on assessed need and not limited by diagnosis or age
- Temporary relief to caregivers
- May have associated charges

Adult Day/Night Programs

- Include social activities, personal care and nursing care

Volunteer Services
Palliative Care
Rehabilitative Care
Residential Long-Term Care
Crisis Intervention
Public Health Inspection and Monitoring
Immunization and Communicable Disease Control
Education and Health Promotion

- Accident prevention, including poisoning prevention, back injury prevention and traffic safety
- Fitness and recreation
- Tobacco, alcohol and other drugs
- Family planning
- Reproductive health
- Dental health and community fluoride programs
- Family violence
- Communicable diseases, including AIDS and other sexually transmitted diseases
- Mental health and mental disorders

- Stress management
- Self-esteem

Nutrition Services
Screening Programs for Children
Pre- and Post-natal Programs
Parent Education Programs
Early Childhood Psychology Services
Mental Health Services for Children and Adults
Suicide Prevention
Rehabilitation Services for Persons with Chronic Mental Disorders
Services for Youth and Adult Offenders
Services for Alcohol and Other Drug Abuse
Speech and Language Services

Manitoba

- Core services are based on the Manitoba Health Goals
- Core services include the full range of health services now funded by Manitoba Health and to which all Manitobans must have access
- Not all services will be provided in each community

Health Promotion/Education

Health Protection
- Communicable disease prevention and control
- Mandated environmental health protection services
- Medical Officer or Health

Prevention and Community Health Services
- Reproductive health, pregnancy/childbirth and parenting
- Services to seniors
- Nutrition education
- Prevention of injury, chronic diseases and substance abuse/addiction
- Family health
- Oral health
- Hearing services
- Diabetes education

Treatment, Emergency and Diagnostic Services
- Treatments services (acute and chronic care services)
- Emergency health services
- Diagnostic services

Developmental and rehabilitation support services
- Rehabilitation therapy
- Early childhood intervention

Home-Based Care Services
- Assessment
- Care planning and co-ordination
- Direct services
- Process for managing long-term care placement

Long-Term Care
- General personal care home services
- Personal care home services for residents with special needs
- Respite care in personal care homes

Mental Health Services
- Assessment/identification services
- Acute care treatment
- Mobile crisis intervention services
- Crisis stabilization units
- Supportive housing option
- Self-help and family support
- Psycho-social rehabilitation, including vocational services
- Intensive case management
- Long-term care/treatment capacity
- Prevention/promotion and public education services

Substance Abuse/Addictions
- Detoxification and treatment
- Support

Palliative Care
- Palliative care in hospitals
- Palliative care in the home

New Brunswick

- Information is in the form of recommendations dated February 1999
- Based on a paradigm of community-based needs assessment and services

"The proposed model calls for the consolidation of the full continuum of health care services, from hospital-based care, under Regional Health Authorities" (Page 12). Services for which the Regional Health Authorities would be responsible include:

- Primary care
  - appropriate access at the community level, including appropriate referral to other services
  - co-ordination of care and case management
  - population-based funding model
  - clinical information management systems
  - models of services should follow local needs
  - use of public education and clinical practice guidelines for chronic diseases
  - encourage self-management and support groups for chronic diseases
  - responsibility taken out of hospitals and transferred to community health centres
- Secondary care
  - Extra-Mural Hospital be a vital part of community care centers to provide short-term care upon discharge from hospital
  - designation of services as per Master Plan (to be revised to reflect changes in paradigm to become more community-based)
  - use of technologies and innovative drug therapies that enable people to remain in their communities or to return to them as quickly as possible
- Tertiary care where designated by the Master Plan
  - "That the development of tertiary care service be permitted only where the principles of evidence-based decision-making, critical mass, and linguistic service are met" (Page27)

- Long-term care
    - single entry point with appropriate multi-disciplinary assessment and reassessment
    - use of Extra-Mural Hospital to support long-term care facilities work
- Rehabilitative care
    - increase in audiology services
    - speech and language pathology services, including education and prevention
    - Occupational Therapy and Physiotherapy services
- Short-term care
    - provided by the Extra-Mural Hospital which has been regionalized since 1996. Since then some inconsistencies in practice between regions have developed
- Public Health services
- Ambulance services
- Mental Health services
    - involves clients, families and communities in how services should be provided
    - public education and awareness
    - access to services such as housing, vocational rehabilitation programs, supportive employment programs and respite services for caregivers, at the community level.
- Physician services
    - provincial responsibility
    - looking at remuneration programs beyond fee-for-service

Nova Scotia

Identified for consideration in 1995 as part of clarifying responsibilities of Regional Health Boards. Not acted on to this point.

Acute Care Services

- Surgery: from general up to and including organ transplantation. Most to be provided at the regional level, all at the provincial level and essentially none at the community level
- Anaesthesia: regional and provincial only
- Medicine: all specialties, primarily at provincial level, essentially none except family medicine at the community level
- Obstetrics: all services at regional and provincial levels, only routine pre and post at community level
- Gynaecology: general at all levels, oncology only at provincial
- Pediatrics: general at community and regional levels, all branches at provincial level (including growth and development)
- Intensive Care: Cape Breton and provincial level only
- Diagnostic: essentially all at regional and provincial levels only. Imaging at provincial level only
- Occupational Therapy, Physiotherapy and Pathology: essentially all at the regional and provincial levels only
- Emergency Services: Level 3 at provincial level only, Level 2 at regional level only, Level 1 maybe at community level
- Rehabilitation: Cape Breton and provincial
- Prosthetics: provincial
- Palliative Care: regional and provincial
- Dentistry: all levels
- Restorative Care: regional and provincial
- Geriatrics: regional and provincial

Drug Dependency Services

Prevention and Community Education
- Health promotion
- Education
- Training of Allied Professionals
- Community development

Community-Based Treatment Services
- Assessment
- Intervention
- Detoxification - Day Program
- Therapy/Counseling (treatment education)
- Structured treatment - modular programs

Regional Treatment Services
- Assessment
- Intervention
- Detoxification - Inpatient
- Therapy/Counseling (treatment education)
- Structured Treatment - residential and non-residential

Targeted Dependency Services
- Adolescent treatment
- Women's Drug Dependency Services
- Driving While Impaired

Mental Health Services

Promotion and Prevention
- Community mental health promotion and education
- Community mental health prevention and early intervention

Community-Based Services
- Out-Patient
- Day Hospital/Day Treatment

Facility-Based and Outreach
- Acute in-patient services
- Specialized in-patient services
- Regional crisis services

Specialized Services

Rehabilitation Services
- Individualized case management
- Services

Public Health

Communicable Disease Prevention and Control
- Non-vaccine preventable diseases
- Vaccine preventable diseases
- Outbreak investigation and management

Non-communicable Disease Prevention
- Healthy Beginnings
- Early Childhood
- Modifiable risk factor reduction

Public Health Enhancement
- School-aged children and youth
- Community health promotion fund
- Community social supports

Prince Edward Island

Core Services are defined as those services which must be available and reasonably accessible to all Islanders.

A. Health Assessment
- Reproductive care and child health
- Early childhood health programs

B. Health Protection
- Immunization and communicable disease control
- Environmental health inspections and monitoring
- Community care facilities and private nursing home inspections
- Child care facilities inspection
- Adult protection
- Child protection

C. Health Promotion and Prevention
- Community development
- Health education
- School health

D. Early Intervention, Treatment and Rehabilitation

Youth and Family Services
- Family support programs
- Welfare assistance
- Services to children including protection, placement, adoption, home support and counseling
- Community and residential services to children and youth
- Family court services
- Support services to victims of family violence
- Dental services to children and youth

General Community Services

- Community addiction services
- Physician services
- Community services for mental health problems
- Audiology
- Speech therapy
- Nutrition
- Home care and support services
- Housing
- Support to special disabilities
- Education and support services to diabetics
- Grants and supports NGOs
- Volunteer services

Institutional/Acute/Rehabilitation/Long-Term Care

- Emergency medical services
- Acute care services
- Long-term residential care
- Rehabilitation services
- Approved out-of-province medical services
- Palliative care services
- Acute inpatient mental health services
- Long-term rehabilitative services for mental health problems
- Forensic mental health services
- Detoxification services
- Alcohol and drug rehabilitation services

Program Support Services

- Pharmacy
- Laboratory services
- Ambulance services
- Blood services
- Radiology

Core Services In Other Jurisdictions

Oregon Health Plan

In Oregon, the Medicaid program, which covers costs for persons who are poor and who do not have coverage under private (employer-based) insurance plans, covers the following:

- diagnosis
- physician services
- check-ups: medical and dental
- family planning services
- maternal, prenatal and newborn care
- prescriptions
- hospital services
- comfort care and hospice (palliative care)
- dental services
- alcohol and drug treatment

Services **not** covered include:

- conditions for which there is not useful treatment
- treatments not generally effective
- cosmetic surgery
- most services to help a woman get pregnant
- pain clinics
- weight loss programs

Primary Principle

- "Consisting of consumers and providers of health and social services, the [Health Services] Commission was charged with ranking health care services for coverage [under Medicaid] ***according to their benefit to the entire population being served.*** (My emphasis, NM.) Coverage was to be provided for all conditions above a threshold on the prioritized list, the threshold being set each session by the state legislature on the basis of actuarial estimates an budgetary constraints. To arrive at a preliminary version of the prioritized list of services, the Commission adopted a cost-benefit methodology that ranked conditions and treatments according to four factors:
  - their cost
  - the net duration of benefit
  - physician estimates of the likelihood that treatment could alleviate symptoms or prevent death
  - citizen views on the seriousness of symptoms and functional limitations.

  [Following criticism of a first list] the Commission elected to base its next prioritized list primarily upon ***citizen values that were articulated at the community meetings, giving high ranks to such areas as preventive and maternity care.*** " (My emphasis, NM.)

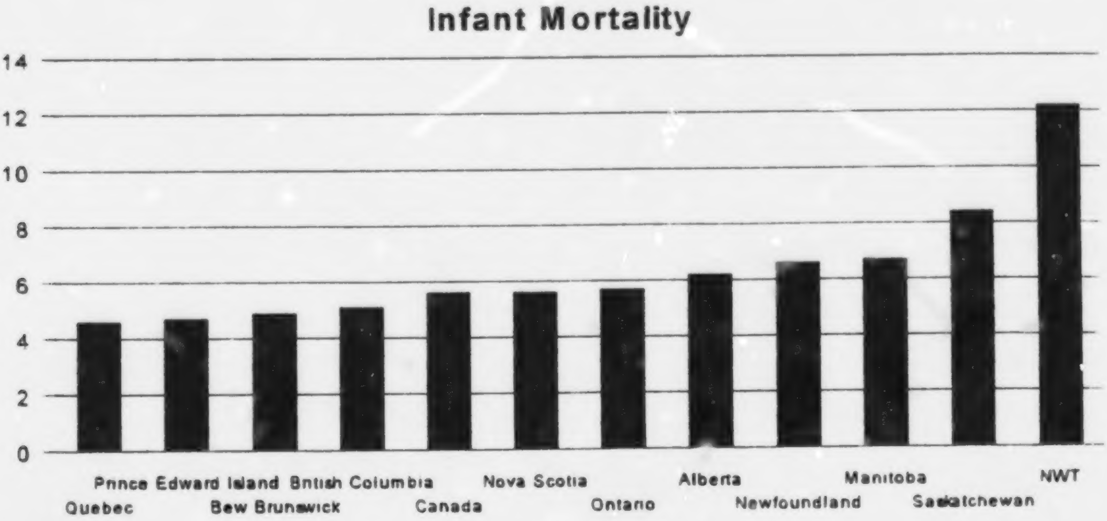
Infant Mortality per 1,000 live births, 1996

Quebec	4.6
Prince Edward Island	4.7
New Brunswick	4.9
British Columbia	5.1
Canada	5.6
Nova Scotia	5.6
Ontario	5.7
Alberta	6.2
Newfoundland	6.6
Manitoba	6.7
Saskatchewan	8.4
Northwest Territories	12.2

Source: Statistics Canada. Compendium of Vital Statistics 1996.

- Infant mortality rates are frequently used as an indicator of child health
- Nova Scotia reported roughly 6 infant deaths per 1,000 live births. This is one of the lowest rates in Canada.

Analysis courtesy of the Population Health Research Unit, Dalhousie University



STATISTICS CANADA

CANADIAN STATISTICS

▷ Canadian Statistics menu | ▷ Health | ▷ Status

Infant mortality rates[1]

	1991	1992	1993	1994	1995
	Rate per 1,000 live births				
Canada	6.4	6.1	6.3	6.3	6.1
Newfoundland	7.8	7.1	7.8	8.2	7.9
Prince Edward Island	6.9	1.6	9.1	6.4	4.6
Nova Scotia	5.7	6.0	7.1	6.0	4.9
New Brunswick	6.1	6.3	7.2	5.4	4.8
Quebec	5.9	5.4	5.7	5.6	5.5
Ontario	6.3	5.9	6.2	6.0	6.0
Manitoba	6.4	6.8	7.1	7.0	7.6
Saskatchewan	8.2	7.3	8.1	8.9	9.1
Alberta	6.7	7.2	6.7	7.4	7.0
British Columbia	6.5	6.2	5.7	6.3	6.0
Yukon	10.6	3.8	7.9	2.3	12.8
Northwest Territories	12.2	16.7	9.6	14.6	13.0

1. The infant mortality rate is calculated as the number of deaths of children less than one year of age per 1,000 live births.

Source: Statistics Canada, Catalogue no. 82-221-XDE.

If you have any questions or would like to obtain more information, contact infostats@statcan.ca

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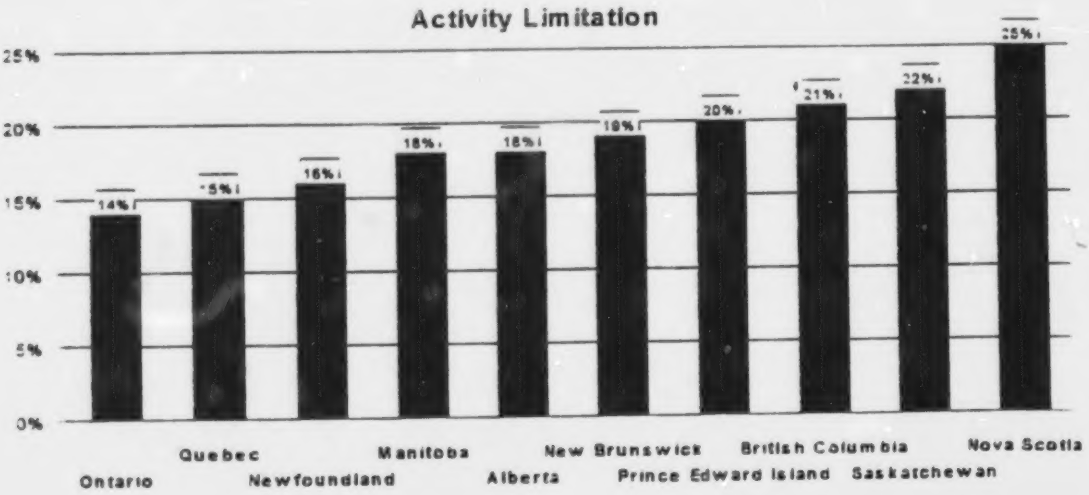
Percent of population aged 12+ with long-term activity limitation *

Ontario	14%
Quebec	15%
Newfoundland	16%
Manitoba	18%
Alberta	18%
New Brunswick	19%
Prince Edward Island	20%
British Columbia	21%
Saskatchewan	22%
Nova Scotia	25%

* Any limitation or disability in normal activities at home, school, or work.



Percent of population aged 12+ in very good health*

Nova Scotia	85 %
Saskatchewan	86 %
British Columbia	86 %
New Brunswick	87 %
Manitoba	87 %
Canada	88 %
Ontario	88 %
Alberta	88 %
Prince Edward Island	89 %
Quebec	90 %
Newfoundland	91 %

* as measured by a score of 0.80 - 1.00 based on eight attributes: vision, hearing, speech, mobility, dexterity, cognition, emotion, and pain/discomfort.

Source: Statistics Canada, National Population Health Survey, 1996 - 97

Incidence (%) of low income[a] 1997

	Canada	Nfld	PEI	NS	NB	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	BC
All persons	17.5	19.8	13.4	17.5	16.8	20.4	15.8	19.4	15.8	15.7	18.2
Elderly Males	11.7	14.0	10.5	9.0	8.0	18.6	8.4	13.3	5.6	8.3	13.0
Elderly Females	24.0	23.2	18.2	16.2	19.7	34.8	18.6	29.6	19.6	17.8	25.3
Children in 2 parent family	13.1	17.4	8.4	13.0	13.4	13.5	13.9	13.3	8.5	10.2	13.5
Children in female headed lone-parent family	59.5	72.3	63.4	70.6	58.5	59.3	59.2	70.2	65.6	58.2	52.3
Persons aged 18-64	16.4	18.8	12.5	16.6	16.0	18.9	14.6	17.6	14.7	15.9	17.3

a "Low income" refers to economic families and unattached individuals who have income below Statistics Canada's Low Income Cut-Offs, 1992 base. Families and unattached individuals with incomes below these limits usually spend more than 54.7% of their income on food, clothing and shelter.

Source: Statistics Canada. Catalogue 13-569-XIB.

[PRINT TABLE]

- Nova Scotia recorded 17.5% of its population as being of "low income" in 1997. The province ranked fifth in the country.
- Low income prevalence was relatively low among the elderly Nova Scotians (aged 65+) and very high among children in female headed lone-parent families (70.6%).

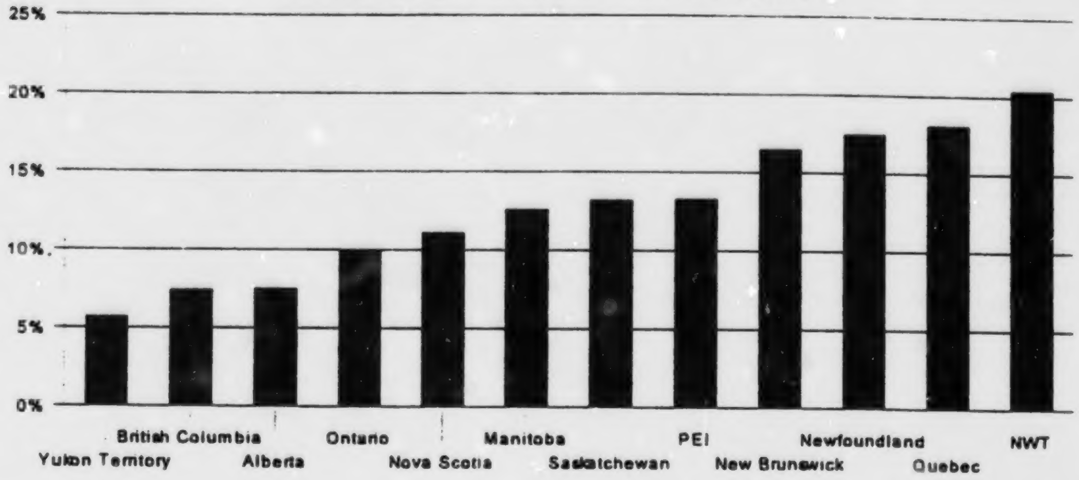
Less Than Grade 9 eduction, population as a % of total population 15 yrs +

Yukon Territory	5.7%
British Columbia	7.4%
Alberta	7.5%
Ontario	10.0%
Nova Scotia	11.1%
Manitoba	12.6%
Saskatchewan	13.2%
Prince Edward Island	13.3%
New Brunswick	16.5%
Newfoundland	17.5%
Quebec	13.1%
Northwest Territories	20.4%

Source: Statistics Canada. 1996 Census

- Level of education is a powerful predictor of employment opportunities and ability to advance within a profession. It is also a powerful predictor of health status in that persons with higher levels of education generally have a better health status and longer life expectancy than persons with lower levels of education.
- Grade 9 is often used as a cut-off point for "functional literacy". Adults with less than a grade 9 education face substantial literacy-related challenges.

Analysis courtesy of the Population Health Research Unit, Dalhousie University



Less than Grade 9 Education

STATISTICS CANADA CANADIAN STATISTICS

▷ Canadian Statistics menu | ▷ Health | ▷ Status

Selected leading causes of death by sex

	1995				
	Number	%	Total	Males	Females
			Rate[1]		
All causes	**210,733**	**100.0**	**666.9**	**857.8**	**522.5**
Cancers	57,810	27.4	184.9	234.7	150.3
Diseases of the heart	57,461	27.3	179.9	238.7	134.8
Cerebrovascular diseases	15,537	7.4	48.1	53.5	44.0
Chronic obstructive pulmonary diseases and allied conditions	9,185	4.4	28.8	44.7	19.3
Accidents and adverse effects	8,823	4.2	29.0	39.9	18.5
Pneumonia and influenza	7,382	3.5	22.7	29.6	18.5
Diabetes mellitus	5,496	2.6	17.4	20.9	14.6
Diseases of arteries, arterioles and capillaries	4,858	2.3	15.1	20.6	11.2
Hereditary and degenerative diseases of the central nervous system	4,762	2.3	14.8	16.4	13.6
Suicide	3,963	1.9	13.3	21.5	5.3
Psychoses	3,780	1.8	11.5	11.0	11.4
Nephritis, nephrotic syndrome and nephrosis	2,598	1.2	8.1	10.9	6.3
Chronic liver disease and cirrhosis	2,235	1.1	7.2	10.6	4.4
HIV infection	1,764	0.8	5.8	10.7	0.9
Neurotic disorders, personality disorders and other nonpsychotic mental disorders	1,265	0.6	4.0	5.3	2.8

[1] Age-standardized mortality rate per 100,000 population.

Source: Statistics Canada, Catalogue no. 84-210-XIB.

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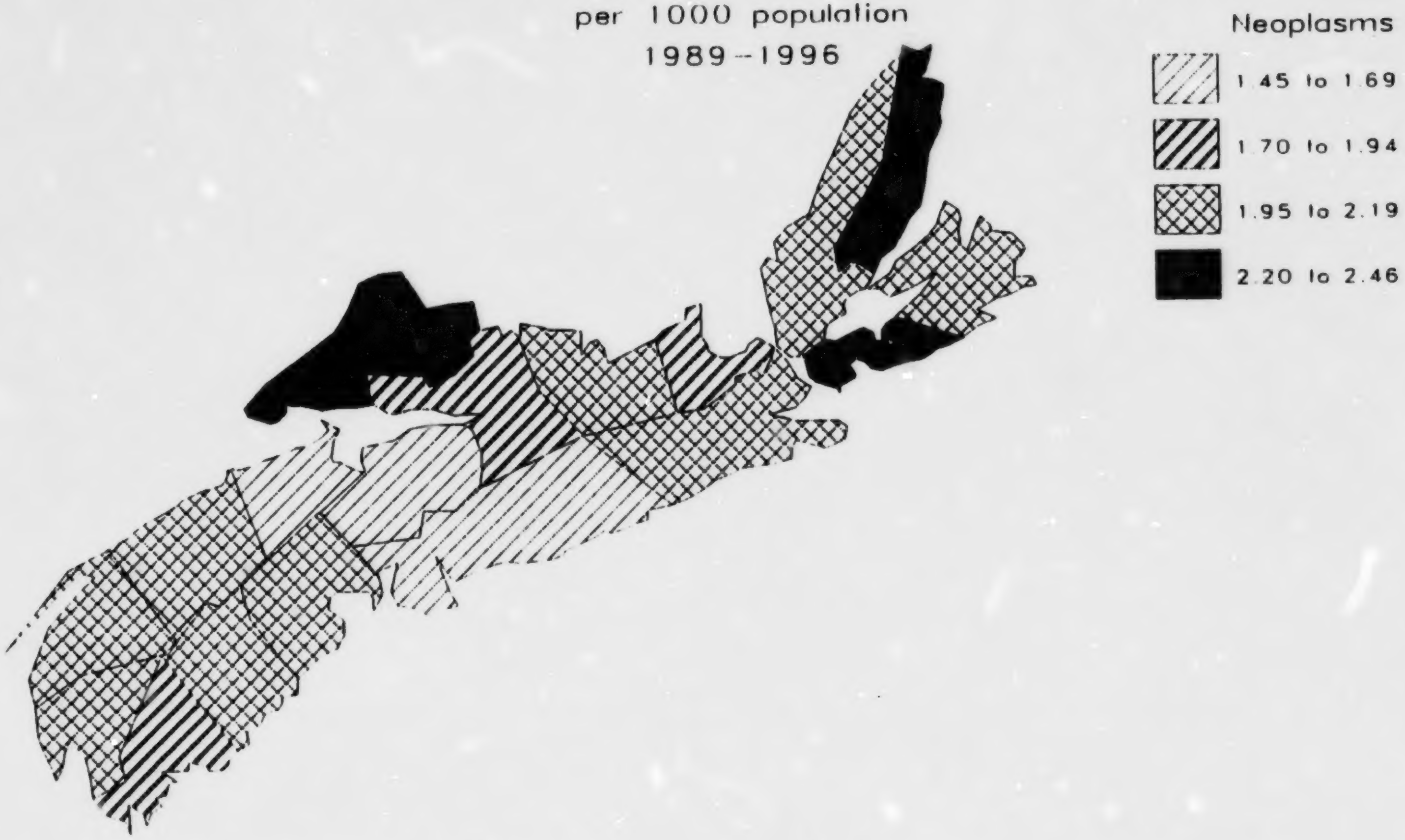
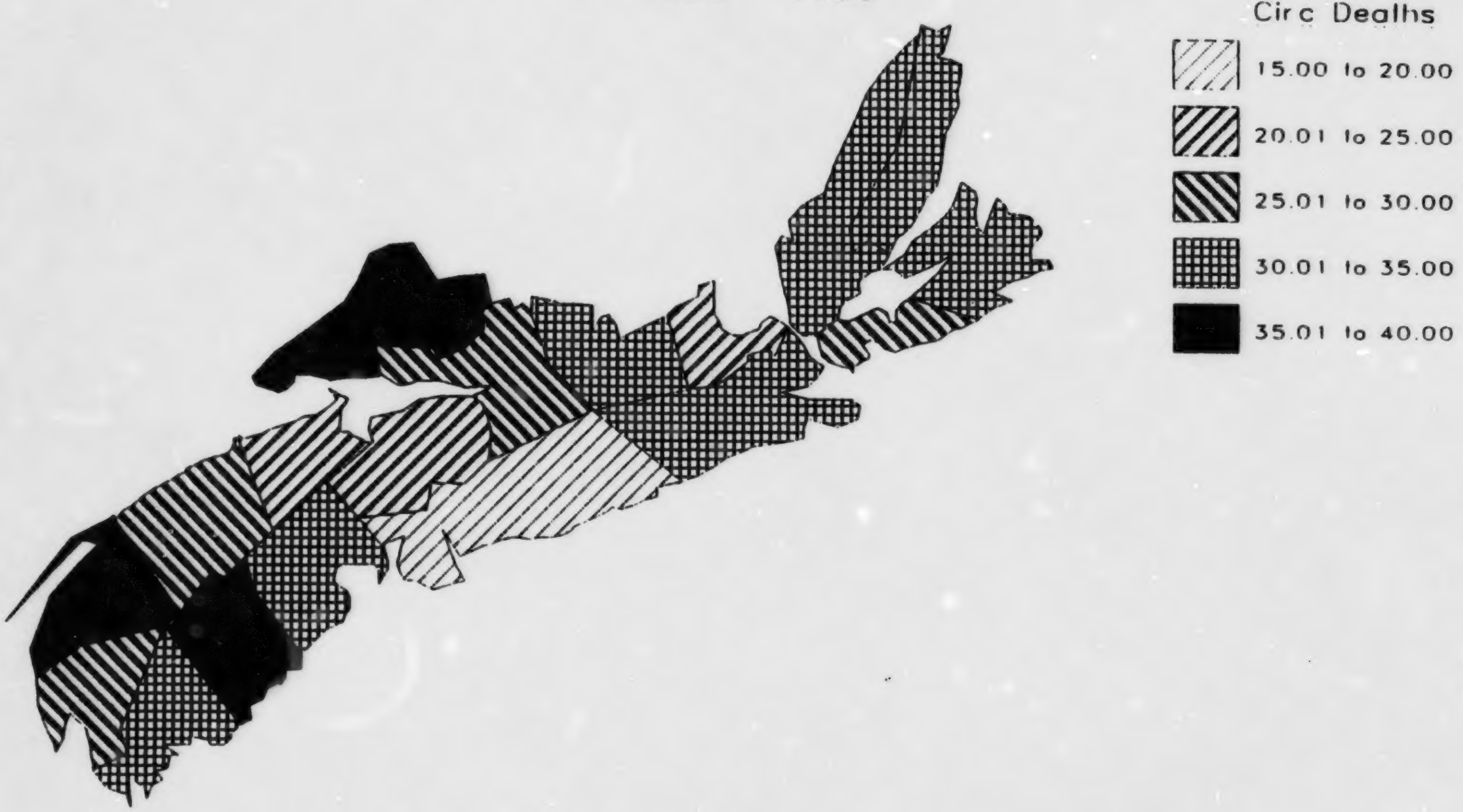
Neoplasms Causing Death

per 1000 population

1989–1996


Neoplasms
1.45 to 1.69
1.70 to 1.94
1.95 to 2.19
2.20 to 2.46



Deaths Due to Circulatory System

per 1000 population

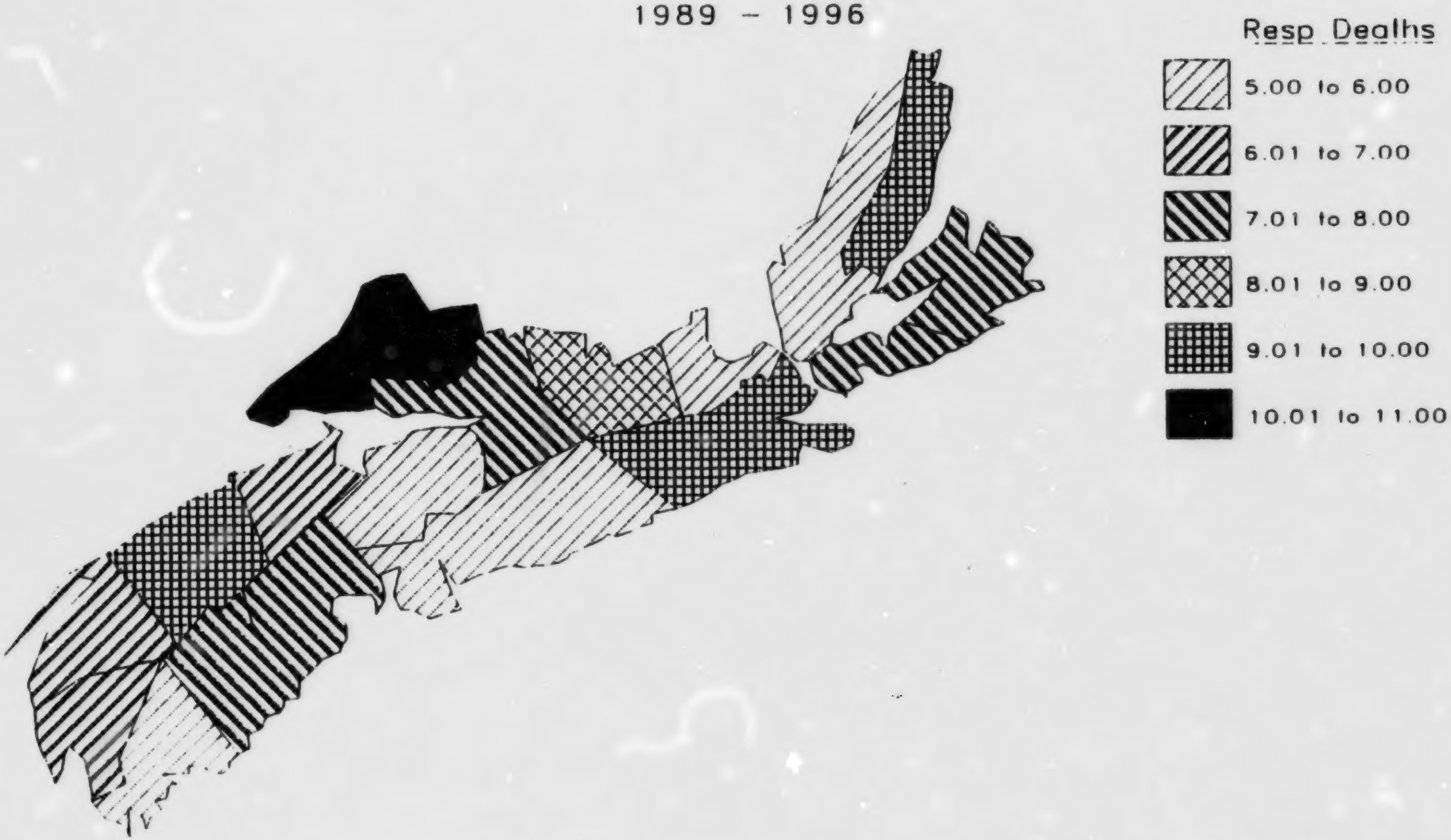
1989 - 1996

Circ Deaths
▨ 15.00 to 20.00
▨ 20.01 to 25.00
▨ 25.01 to 30.00
▦ 30.01 to 35.00
■ 35.01 to 40.00

Deaths Due to Respiratory System

per 1000 population

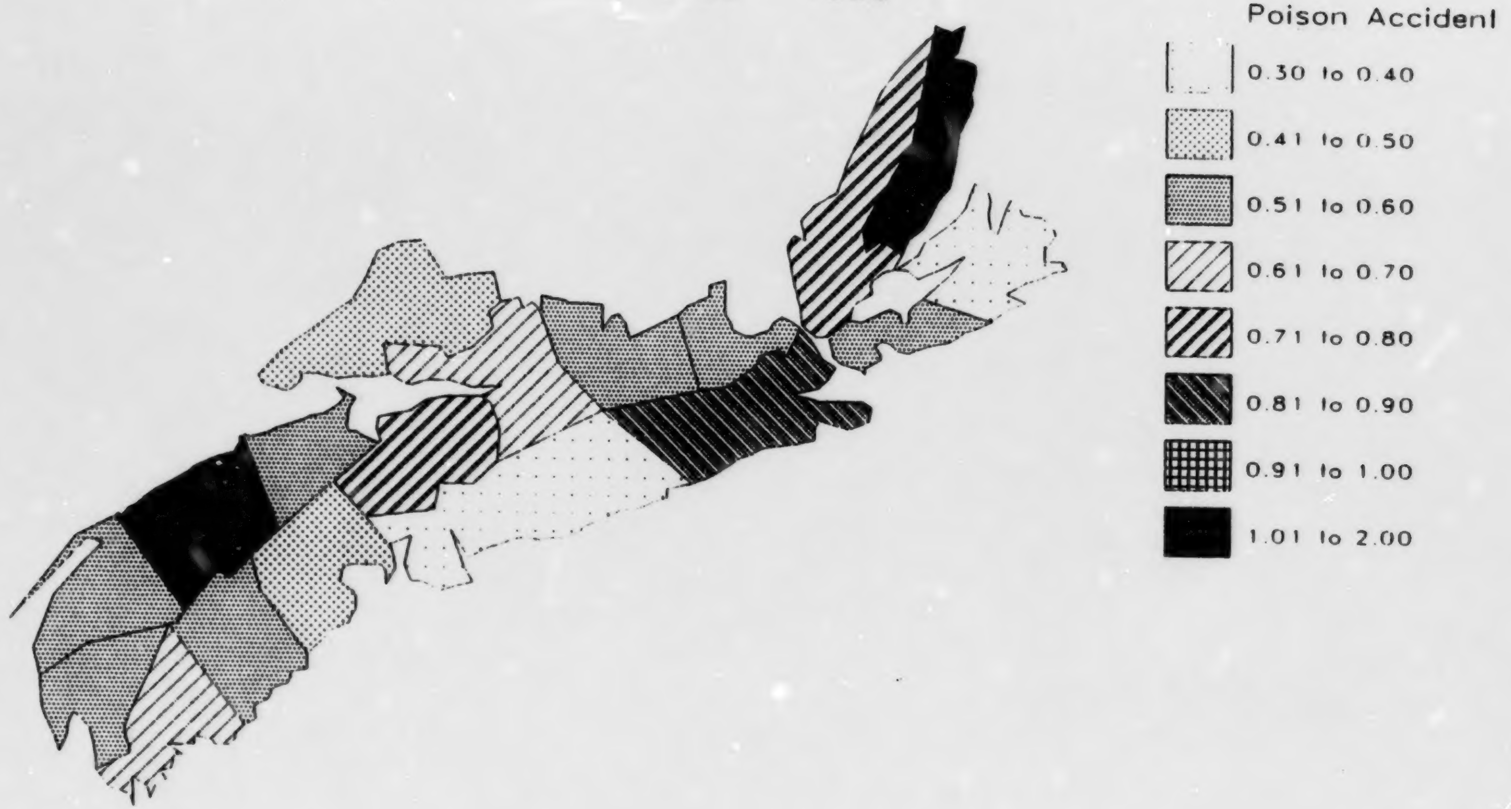
1989 - 1996


Resp Deaths
5.00 to 6.00
6.01 to 7.00
7.01 to 8.00
8.01 to 9.00
9.01 to 10.00
10.01 to 11.00

Poisoning / Accidents Causing Death

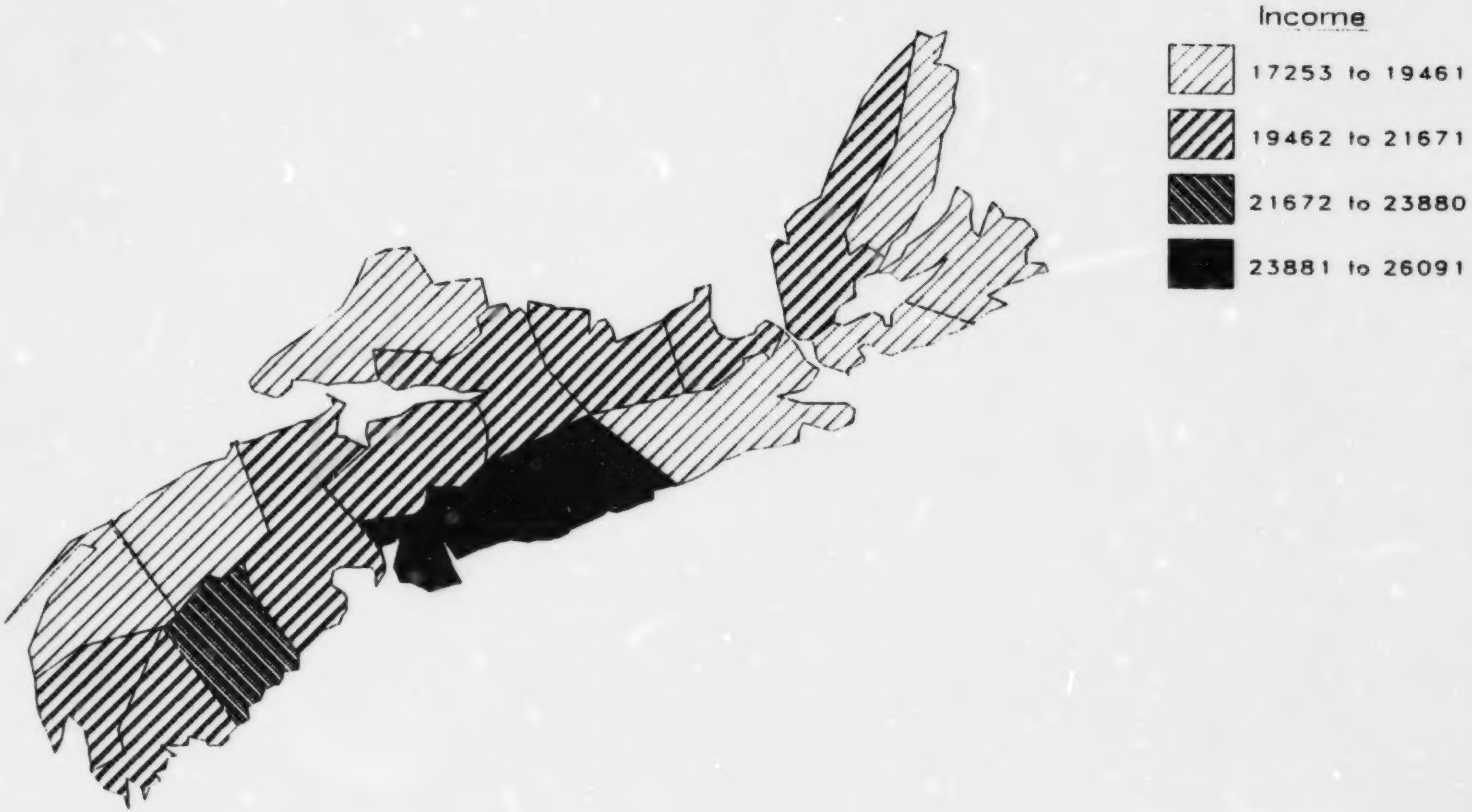
per 1000 population

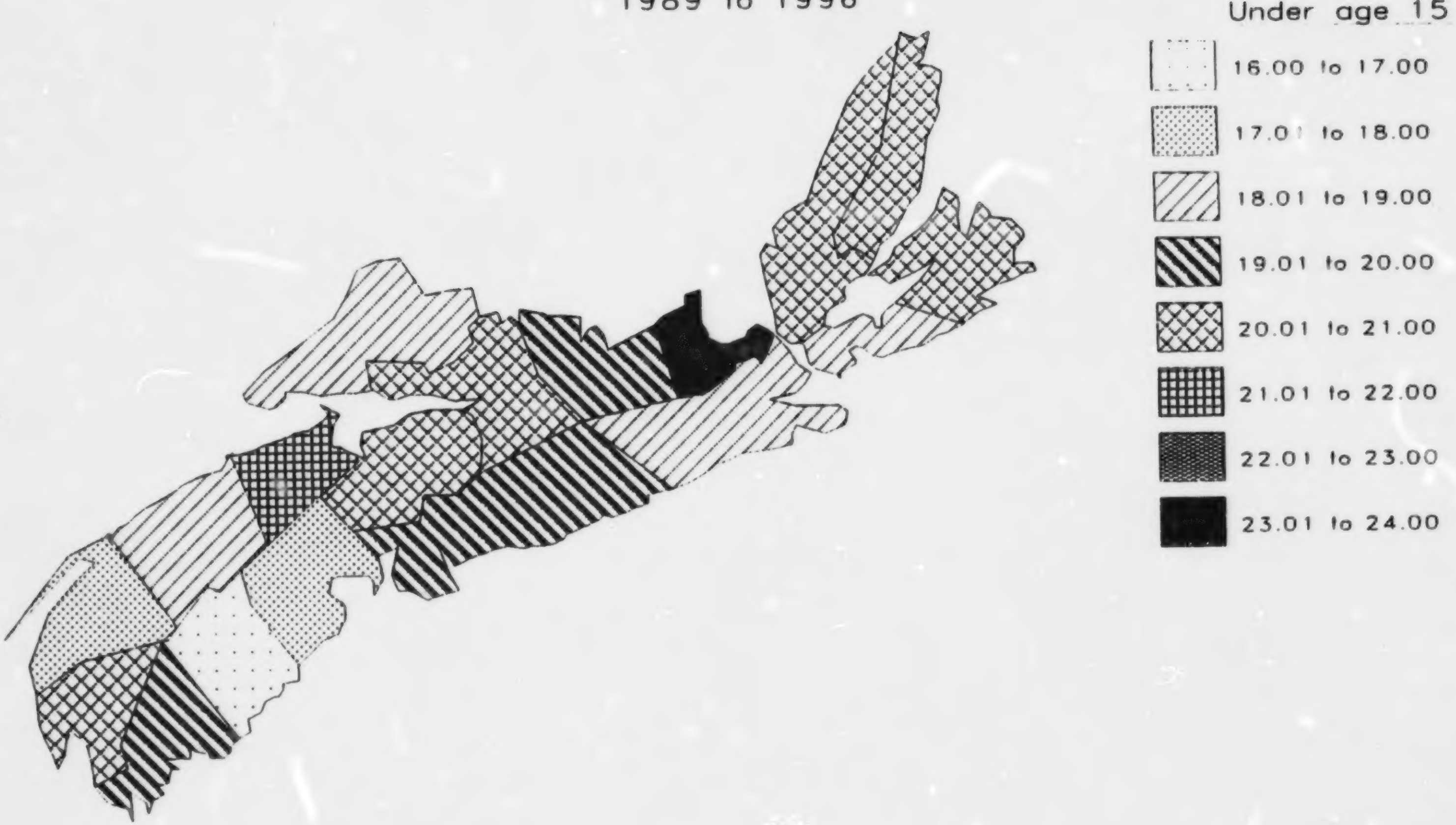
1989 - 1996


Poison Accident
0.30 to 0.40
0.41 to 0.50
0.51 to 0.60
0.61 to 0.70
0.71 to 0.80
0.81 to 0.90
0.91 to 1.00
1.01 to 2.00

Individual Income

1998


Income
17253 to 19461
19462 to 21671
21672 to 23880
23881 to 26091

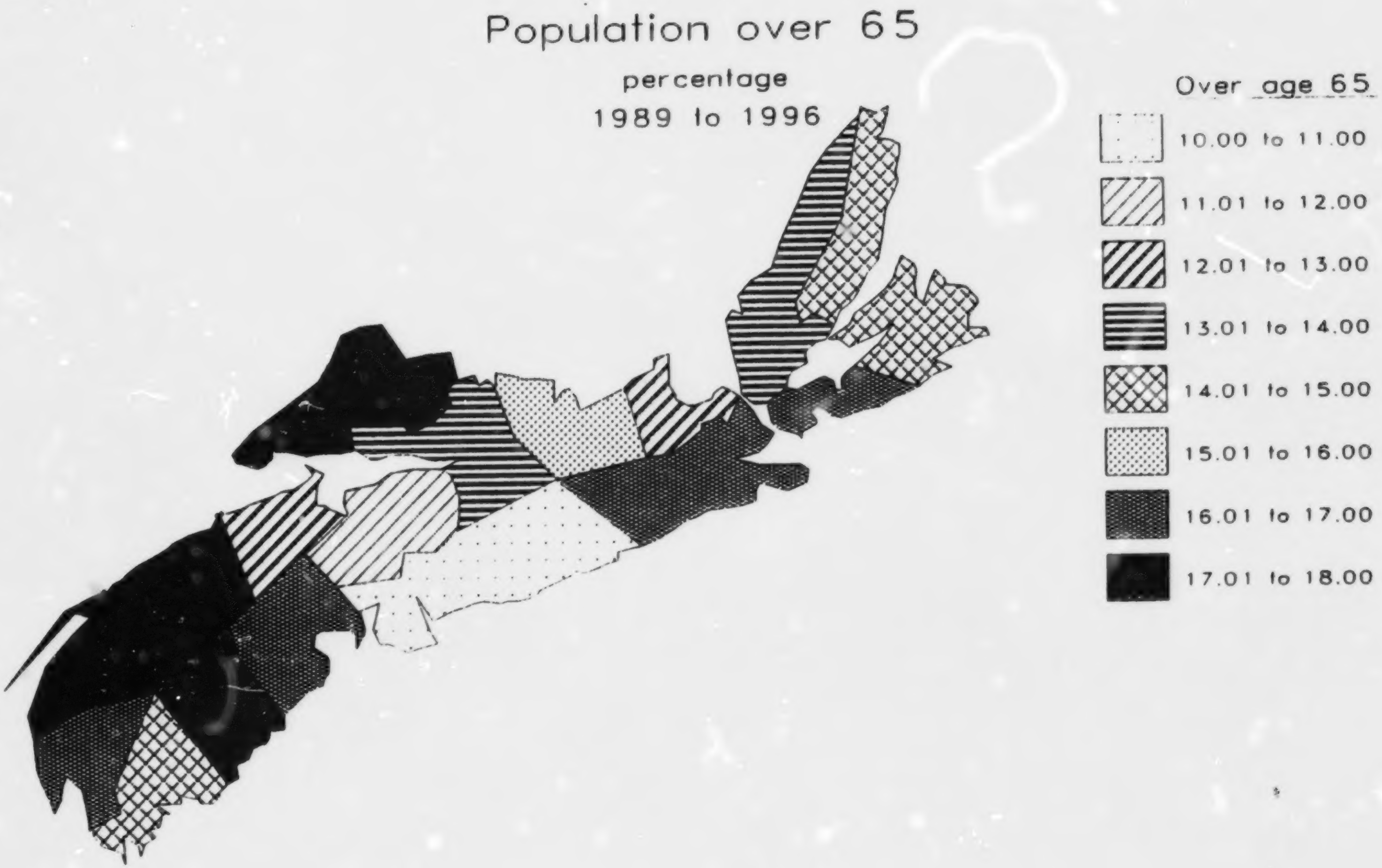


Population Under 15

percentage

1989 to 1996

Under age 15
16.00 to 17.00
17.01 to 18.00
18.01 to 19.00
19.01 to 20.00
20.01 to 21.00
21.01 to 22.00
22.01 to 23.00
23.01 to 24.00



Population over 65

percentage

1989 to 1996

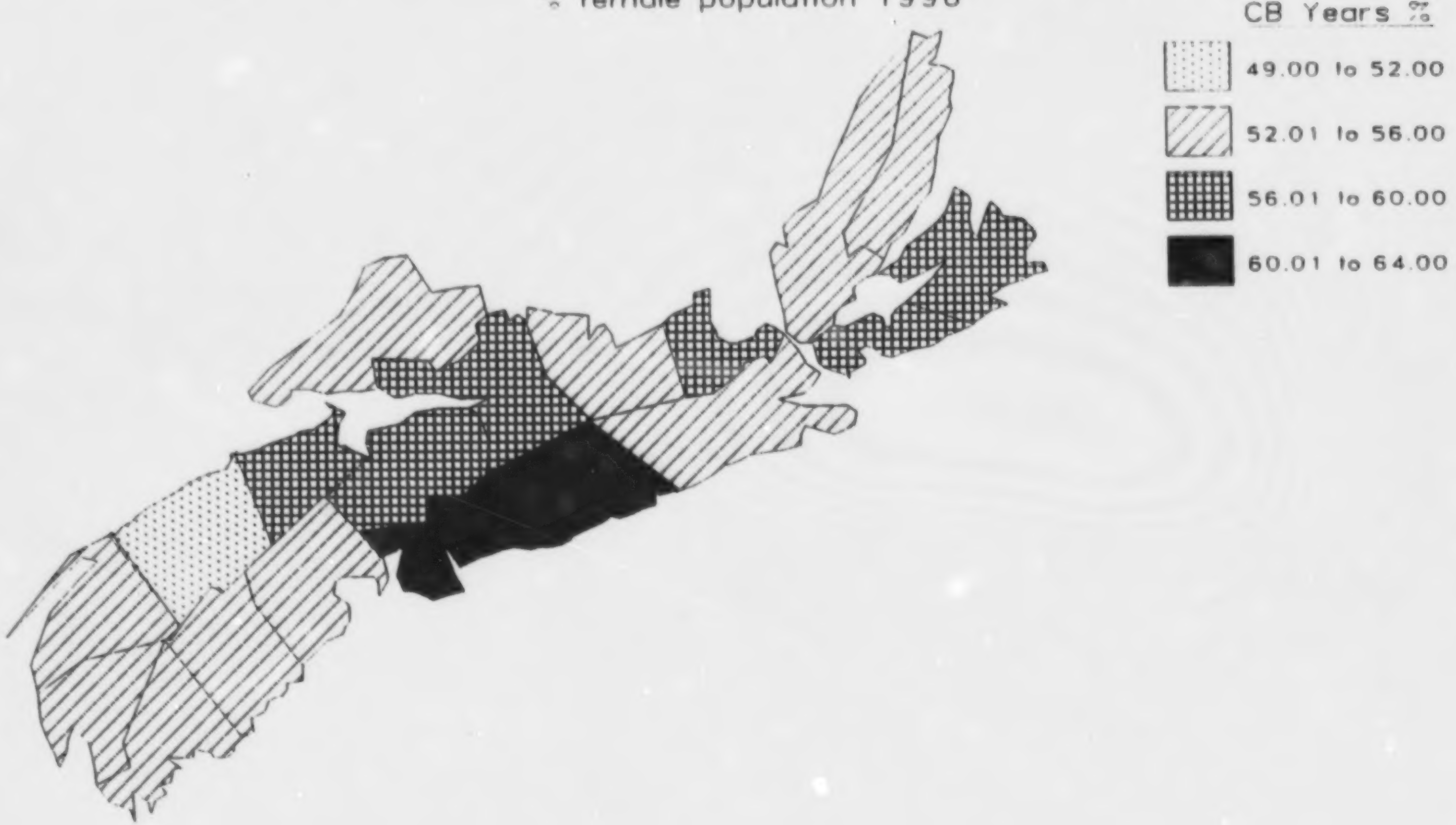
Over age 65
10.00 to 11.00
11.01 to 12.00
12.01 to 13.00
13.01 to 14.00
14.01 to 15.00
15.01 to 16.00
16.01 to 17.00
17.01 to 18.00

X

Women of Child Bearing Years

age 15 to 54

% female population 1996


CB Years %
49.00 to 52.00
52.01 to 56.00
56.01 to 60.00
60.01 to 64.00

Low birth weight[a]

Yukon	4.3
Saskatchewan	5.0
New Brunswick	5.1
British Columbia	5.2
Prince Edward Island	5.3
Nova Scotia	5.4
Manitoba	5.5
Northwest Territories	5.5
Canada	5.8
Quebec	5.9
Ontario	6.0
Newfoundland	6.1
Alberta	6.1

a Percentage of all live births less than 2,500 grams. 1996.

Source: Statistics Canada. The Daily, July 8, 1998.

[PRINT TABLE]

- Low birthweight infants are at risk for the development of a variety of health problems.
- Nova Scotia reported 5.4% of all infants born in 1996 being of low birth weight. The province ranked sixth among the 12 provinces and territories.

Population Health Research Unit

Disability days in the previous two weeks

Quebec	0.64
Prince Edward Island	0.80
Ontario	0.80
Newfoundland	0.81
Saskatchewan	0.93
Alberta	1.00
Manitoba	1.02
New Brunswick	1.02
British Columbia	1.05
Nova Scotia	1.05

Source: Statistics Canada. National Population Health Survey 1996-97.

[PRINT TABLE]

- Nova Scotians and British Columbians reported the highest incidence of "disability days" in the country.
- These rates have been age-standardized indicating that the effects of different age-distributions of the provincial populations have been removed.

Population Health Research Unit

Potential years of life lost per 100,000 population

	Total	Cancer	Accidents	Suicide	Respiratory	Heart disease	Stroke	Other
Canada	3,804	1,098	746	417	113	491	91	848
Newfoundland	3,721	1,152	759	224	77	663	110	737
Prince Edward Island	3,687	1,189	829	188	144	642	138	557
Nova Scotia	3,983	1,264	860	367	147	592	64	689
New Brunswick	3,736	1,126	758	394	77	589	82	711
Quebec	4,032	1,192	735	660	108	521	98	717
Ontario	3,453	1,079	601	284	110	475	93	810
Manitoba	4,066	1,147	936	351	140	546	121	824
Saskatchewan	4,203	1,086	964	508	161	523	82	879
Alberta	3,943	1,009	963	529	129	492	86	735
British Columbia	3,986	960	828	279	102	385	75	1,357
Yukon	4,742	775	1,788	457	86	559	0	1,078
Northwest Territories	7,695	1,479	2,309	1,480	370	481	269	1,308

Source: Statistics Canada. Health Indicators, 1997.

[PRINT TABLE]

- "Potential years of life lost" is a public health measure used to indicate the contribution of different diseases to mortality before age seventy.
- In Nova Scotia, cancer is the most significant cause of premature mortality.

Population Health Research Unit

Risk of clinical depression, 1994-95

Prince Edward Island	6%
Newfoundland	7%
Saskatchewan	7%
Quebec	8%
Ontario	8%
Alberta	8%
New Brunswick	9%
British Columbia	10%
Nova Scotia	11%
Manitoba	11%

Source: Statistics Canada. National Population Health Survey, 1994-95.

[PRINT TABLE]

- Eleven percent of Nova Scotians were rated to be "at-risk" for clinical depression. This represents the highest rate in the country (tied with Manitoba)

Population Health Research Unit

Percent of population aged 20-64 reported as being overweight [a]

Quebec	27%
British Columbia	27%
Canada	29%
Ontario	29%
Alberta	30%
Manitoba	35%
Saskatchewan	36%
Prince Edward Island	37%
Nova Scotia	38%
Newfoundland	39%
New Brunswick	42%

a Body Mass Index (weight in kilograms/[height in metres, squared]) 27.0 or greater

Source: Statistics Canada. National Population Health Survey 1996-97.

[PRINT TABLE]

- Obesity is a risk factor for hypertension, diabetes and other poor health outcomes
- Nova Scotia recorded 38% if its population aged 20-64 being overweight in 1996-97.

Population Health Research Unit

Prevalence of high blood pressure[a] among ages 18-74, 1986-92

Alberta	18%
Quebec	19%
British Columbia	20%
Saskatchewan	21%
Manitoba	22%
Prince Edward Island	24%
Ontario	24%
Nova Scotia	26%
New Brunswick	26%
Newfoundland	27%

[a] 140/90 mm or greater and/or on treatment for hypertension

Source: Canadian Provincial Heart Health Surveys Research.

[PRINT TABLE]

- Nova Scotia recorded 26% of its population as having high blood pressure, over a period of seven years.
- This is one of the highest percentages in Canada, second to Newfoundland.

Population Health Research Unit

Prevalence of high plasma cholesterol[a], %, ages 18-74, 1986-92

Alberta	11.0
Ontario	12.0
Newfoundland	14.0
Nova Scotia	15.0
Manitoba	15.0
Prince Edward Island	16.0
Saskatchewan	17.0
British Columbia	17.0
New Brunswick	18.0
Quebec	19.0

a 6.2+ mmol/L

Source: Canadian Provincial Heart Health Surveys Research Group.

[PRINT TABLE]

- Fifteen percent of Nova Scotians aged 18-74 were reported as having high blood cholesterol over a seven year period.
- This figure lies mid-range between the lowest rate recorded in Alberta to the highest rate recorded in Quebec.

Population Health Research Unit

Self Rated Health Status- Percent rating Health Status as "Very Good" or "Excellent" (age-standardized)

New Brunswick	57%
Saskatchewan	57%
Nova Scotia	59%
Manitoba	61%
Quebec	63%
British Columbia	63%
Ontario	64%
Newfoundland	67%
Prince Edward Island	67%
Alberta	67%

Source: Statistics Canada. National Population Health Survey. Original analysis

[PRINT TABLE]

- Fifty nine percent of Nova Scotians rated their health status as "very good" or "excellent" in 1994-95.
- Only New Brunswick and Saskatchewan reported smaller proportions of their populations with these ratings

Population Health Research Unit

Unemployment rate, population 15-24

Alberta	13.0%
Manitoba	14.1%
Saskatchewan	14.3%
British Columbia	15.9%
Yukon Territory	16.9%
Ontario	17.8%
Prince Edward Island	18.7%
Quebec	19.1%
Northwest Territories	22.5%
Nova Scotia	23.3%
New Brunswick	24.7%
Newfoundland	36.9%

Source: Statistics Canada. 1996 Census.

[PRINT TABLE]

- Twenty three percent of Nova Scotia's youth were unemployed in 1996.
- This represents the third highest rate in the country.

Population Health Research Unit

Unemployment rate females, 15+

Saskatchewan	7.0%
Alberta	7.1%
Manitoba	7.1%
British Columbia	9.2%
Ontario	9.6%
Yukon Territory	9.9%
Quebec	11.2%
Northwest Territories	11.4%
Nova Scotia	12.9%
New Brunswick	14.0%
Prince Edward Island	14.1%
Newfoundland	22.9%

Source: Statistics Canada. 1996 Census.

[PRINT TABLE]

- Roughly 13% of Nova Scotia females aged 15+ were unemployed in 1996.
- Nova Scotia had one of the four highest rates in Canada in that year.

Population Health Research Unit

Unemployment rate males 15+

Alberta	7.3%
Saskatchewan	7.4%
Manitoba	8.5%
Ontario	8.7%
British Columbia	9.8%
Yukon Territory	12.1%
Quebec	12.3%
Nova Scotia	13.5%
Prince Edward Island	13.5%
Northwest Territories	14.1%
New Brunswick	16.7%
Newfoundland	26.9%

Source: Statistics Canada. 1996 Census.

[PRINT TABLE]

- Almost 14% of the Nova Scotia male population aged 15+ were unemployed in 1996.
- Nova Scotia had one of the top five rates in the country for that year.

Population Health Research Unit

Gross rent spending 30% or more as a % of total number of rented dwellings

Northwest Territories	12.8%
Yukon Territory	28.1%
Saskatchewan	35.6%
Alberta	37.1%
Manitoba	39.8%
New Brunswick	41.9%
Prince Edward Island	42.1%
Quebec	42.3%
Newfoundland	43.2%
Ontario	44.1%
British Columbia	46.1%
Nova Scotia	47.1%

Source: Statistics Canada. 1996 Census.

[PRINT TABLE]

- The proportion of renters devoting more than 30% of their income to rental payments is used as an indicator of "financial stress".
- In Nova Scotia, 47.1% of renters fell into this group in 1996. This represented the highest rate in the country.

Population Health Research Unit

Perinatal mortality[a] rate per 1,000 births

Yukon	4.5
Quebec	5.7
Nova Scotia	6.2
New Brunswick	6.2
British Columbia	6.2
Canada	6.7
Newfoundland	6.9
Alberta	7.0
Saskatchewan	7.1
Ontario	7.2
Manitoba	7.6
Northwest Territories	7.6
Prince Edward Island	7.7

[a] Stillbirths and infant deaths under one week of age

Source: Statistics Canada. Compendium of Vital Statistics. 1996.

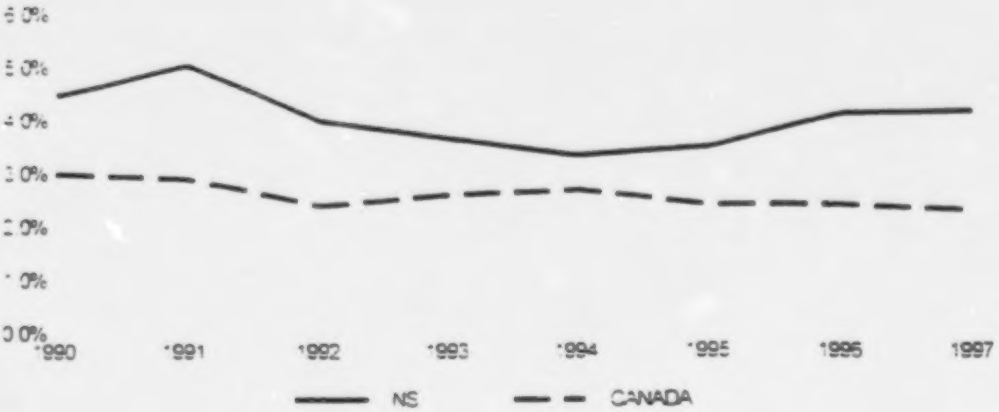
[PRINT TABLE]

- In 1996. Nova Scotia recorded roughly six perinatal deaths per 1.000 births.

Population Health Research Unit

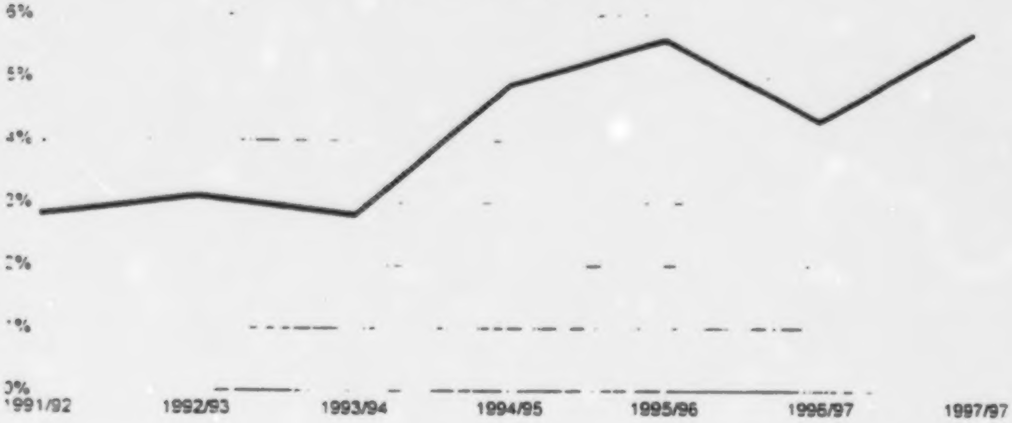
CERVICAL CANCER MORTALITY RATES

Nova Scotia and Canada - 1990 to 1997



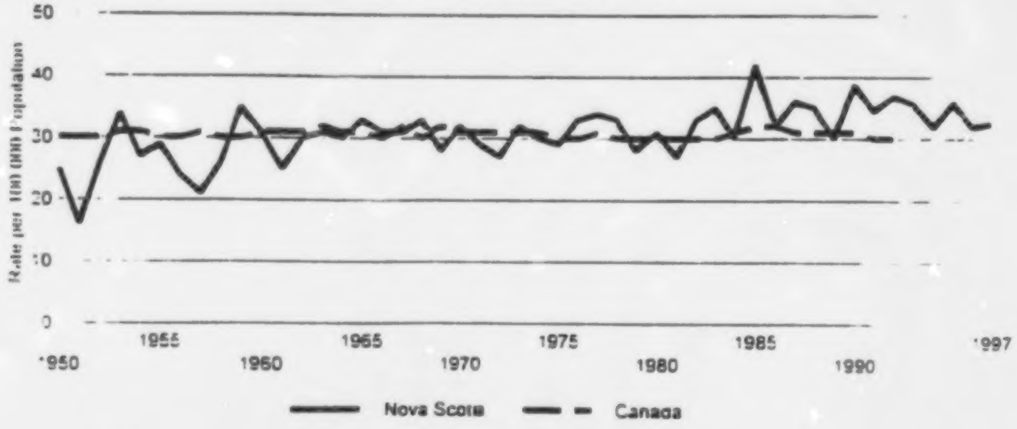
MAMMOGRAPHY SCREENING PROVINCE - WIDE RATE

Percentage of Women Screened - (Aged 50 to 69 Years)
1991/92-1997/98



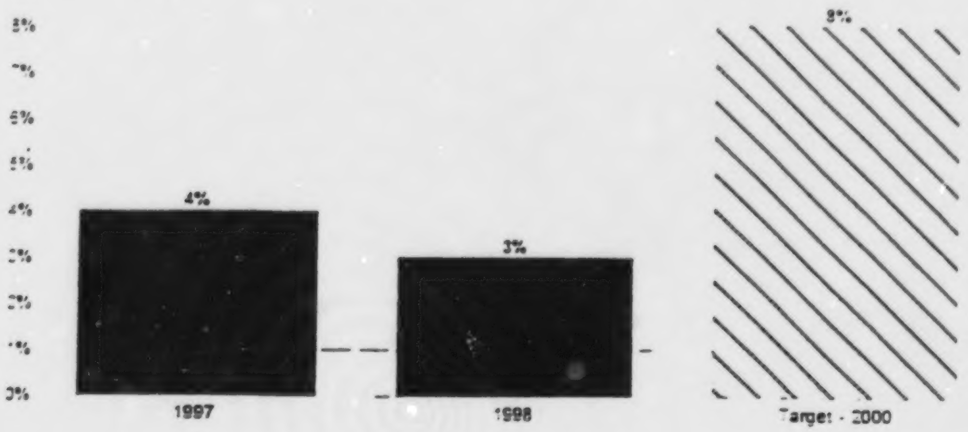
BREAST CANCER MORTALITY RATES

Nova Scotia and Canada - 1950 to 1997 - Age-Standardized Rates per 100,000 of the Female Population



SURVIVAL RATES FOR OUT OF HOSPITAL CARDIAC ARRESTS

For 1997 and 1998 with Year 2000 Target



DRAFT-- FOR DISCUSSION **September 1999**

Quality of Life Impact Assessment Tool

1. **The following is a checklist to help you consider potential impacts of this initiative on the quality of life of Nova Scotians, and to identify potential partners.**

	Some Factors to Consider
a) ***There is strong and growing evidence that higher socioeconomic status is associated with better quality of life.*** — How could this initiative affect employment opportunities for individuals and communities [particularly disadvantaged groups]?	***Is there an impact on:*** *** communities & population groups experiencing high unemployment rates** *** stability of work** *** use of existing workforce skills, & development of additional transferable skills** *** access to quality child care?**
b) ***The narrower the spread of incomes in any given society, the narrower the gulf in its overall quality of life.*** — How could this initiative affect the spread of incomes between socioeconomic groups?	***Is there an impact on:*** *** number of individuals in poverty** *** economic situation for women, children, youth, and seniors** *** economic situation for minority and disadvantaged groups** ***economic development?**
c) ***The economic prosperity of a society, and the quality of life of its population are inextricably linked.*** — How could this initiative affect the development of the economy?	***Is there impact on:*** *** number of jobs created or lost** *** number of persons receiving EI and social assistance benefits** *** number of individuals living in poverty?**
d) ***A key influence on quality of life is the degree of control people have over life circumstances and their discretion to act.*** — How could this initiative affect the degree of control people have over life circumstances?	***Is there impact on:*** *** physical and socioeconomic barriers for disadvantaged and minority groups** *** caregivers in the home** *** support for families** ***creation of meaningful work** *** local governance?**
e) ***Unequal access to society's services, programs, opportunities, and resources impact negatively on the social and economic conditions associated with quality of life.*** — How could this initiative affect equity of access to services, programs, opportunities, and resources particularly for women, visible minorities, immigrants, the disabled, and the poor?	***Is there an impact on:*** *** Aboriginal people, cultural and linguistic minorities** ***women, children, youth, and seniors** ***people with disabilities, illiteracy, or mental health problems?** *** gays, lesbians, bisexuals**

draft

f) "Strong, independent and responsible individuals grow best in nurturing, positive and supportive environments".

—— How could this initiative affect the ability of families and communities to provide nurturing, positive, and supportive environments in which to raise children?

Is there an impact on:
*** meeting nutritional requirements and other basic physical needs (e.g., clothing, housing)**
***access to exercise and recreation**
*** strength of nurturing bonds**
***play and learning that builds self-esteem**
*** safety of communities and play areas?**

g) Our quality of life is critically dependent on the physical environments in which we live.

—— How could this initiative affect the physical environments in which we live including man made (e.g., homes, communities, workplace, schools), and natural (e.g., air, land, water, ecosystem)?

Is there an impact on:
*** efforts to recycle, reduce, re-use**
*** quality of land, air, water**
*** biological diversity**
*** safety and function of buildings (e.g., homes, schools, workplace, recreation facilities)**
*** rates and fear of crime?**

h) People are social beings. Meaningful social contacts have a significant impact on quality of life.

—— How could this initiative affect the number and quality of people's supportive social and family relationships [particularly disadvantaged groups]?

Is there an impact on:
*** connectedness with family, friends, co-workers, neighbours**
*** participation in volunteer, neighbourhood, and community activities**
*** opportunities for leisure and fitness activity**
*** participation in cultural and spiritual activities?**

I) Education is directly linked with social and economic conditions associated with quality of life.

—— How could this initiative affect educational opportunities at all stages of life?

Is there an impact on:
*** appropriate educational opportunities for people of all ages and income levels**
*** skill development for existing and future job opportunities**
*** quality of learning environments**
*** educational opportunities for people who have special learning needs?**

2. *Policy and program decisions made by one department usually have a direct or indirect impact on issues within the policy realm of other departments. Working collaboratively will enhance the quality of life of Nova Scotians by reducing the negative effects of contradictory public policy.*

How will other public policy sectors be affected by this initiative?

Provincial Government Departments:

- **Agriculture and Marketing**
- **Business and Consumer Services**
- **Community Services**
- **Economic Development**
- **Education**
- **Environment**
- **Finance**
- **Fisheries and Aquaculture**
- **Health**
- **Housing and Municipal Affairs**
- **Human Resources**
- **Justice**
- **Labour**
- **Natural Resources**
- **Technology and Science Secretariat**
- **Transportation and Public Works**
- **Tourism and Culture**

3. *To improve quality of life, we must look beyond the confines of our own department and provincial government. We must look broadly to include partners who will be affected by the policy or program decisions.*

What other partners might be affected by the decision, or have an interest in collaboration in the policy or program development process?

Other partners include:

- **federal and municipal governments**
- **non-government organizations**
- **interest groups**
- **associations**
- **businesses**
- **community and voluntary organizations**
- **individuals**

draft

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CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

ACUTE CARE

Acute Care core services developed in draft form in 1996 but not released as policy.

Tertiary/Provincial Level Acute Care Services	Secondary/Regional Level Acute Care Services	Primary/Community Level Acute Care Services
must be provided **Surgery** • cardiac surgery • general surgery • urology surgery (incl. Lithotripsy) • neuro surgery • reconstructive & plastic surgery • cardiovascular surgery • orthopedic surgery • oral & maxillofacial surgery • organ transplantation surgery and follow up • vascular & thoracic surgery **Anaesthesia** **Medicine** • cardiology • endocrinology • oncology -medical & radiation • nephrology • ophthalmology • neurology • pain management • hematology • gastroenterology • respirology • rheumatology • dermatology • immunology • otolaryngology	*must be provided* **Surgery** • general surgery • orthopedic surgery • vascular & thoracic surgery **Anaesthesia** **Medicine** • cardiology • ophthalmology • pain management • gastroenterology • respirology • family medicine • otolaryngology **Obstetrics** • routine pre & postnatal care • obstetrics- high & low risk **Gynacology** • general gynaecology **Pediatrics** • general pediatrics **Diagnostics** • radiology	*must be provided* **Medicine** • family medicine **Obstetrics** • pre & postnatal care *may be provided under certain conditions* **Surgery** • general surgery **Medicine** • general medicine • pain management **Pediatrics** • general pediatrics **Diagnostics** • mammography screening • phlebotomy services **Occupational therapy** **Physiotherapy** **Emergency Services** • Level 1

CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

- infectious diseases

Obstetrics
- obstetrics- high & low risk
- routine pre & post natal care

Gynacology
- general
- oncology

Pediatrics
- general pediatrics
- growth & development
- clinical immunology & allergy
- pediatric oncology

Intensive care
- medical/surgical/critical/cardiac
- burns
- neonatal/pediatrics

Diagnostics
- radiology
- mammography screening
- imaging
- phlebotomy services
- laboratory medicine
- medical microbiology

Occupational therapy

Physiotherapy

Pathology

Emergency Services
- Level 3

Rehabilitation

Prosthetics

Palliative care

- mammography screening
- phlebotomy services
- laboratory medicine

Occupational therapy

Physiotherapy

Pathology

Emergency Services
- Level 2

Palliative care

Dentistry

Restorative care

Geriatrics

may be provided under certain conditions
Surgery
- urology surgery
- neuro surgery
- reconstructive & plastic surgery
- oral & maxillofacial surgery
- organ transplantation follow up

Medicine
- oncology -medical & radiation
- neurology
- dermatology

Intensive care
- medical/surgical/critical/ cardiac
- neonatal/pediatrics

Palliative care

Dentistry

CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

Dentistry **Restorative care** **Geriatrics** *May also include* • bone marrow transplants • genetics • dermatology /laser • sleep disorders • speech language pathology	**Diagnostics** • medical microbiology **Emergency Services** • Level 3 **Rehabilitation**	

Note: *Secondary/Regional services were identified for the purpose of advising 4 regions. This document must be adapted if used for more than 4 regions.*

CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

DRUG DEPENDENCY

Drug Dependency core services developed with the field and drafted in 1997.

Prevention & Community Education	• health promotion • education • training of allied professionals • community development
Community-based Treatment Services	• assessment • intervention • detoxification-day program • therapy/counseling (treatment education) • structured treatment-modular programs
Regional Treatment Services	• assessment • intervention • detoxification-in patient • therapy/counseling (treatment education) • structured treatment-residential and non-residential
Targeted Dependency Services	• adolescent treatment • women's drug dependency services • driving while impaired-second offender's program
Structured Treatment	• residential & non-residential rehabilitation program- structured treatment CORE • long term sheltered environment option • halfway sheltered environment option

CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

MENTAL HEALTH

Mental Health core services developed by a Provincial Steering Committee. Service audits are performed on these.

Mental Health promotion, advocacy, education & prevention program	• community mental health promotion & education • community mental health prevention & early intervention
Adult outpatient and outreach mental health program	• out-patient assessment and treatment • day hospital & day treatment • intensive community-based acute treatment services
Adult inpatient program	• acute inpatient services- short stay unit • specialized in-patient services • consultation/liaison services
Specialty programs	• in-hospital treatment or outpatient clinics for specific diagnostic groups • forensic service • psychogeriatrics
Community mental health supports for adults	• individualized case management • support consumers with serious & long term mental health difficulties • consumer empowerment • clubhouse and consumer initiated services
Child & youth mental health program	• inpatient/outpatient outreach • early identification & intervention services • residential care and treatment services

CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

PUBLIC HEALTH

Public health core services and standards developed with the field and drafted in 1997. Currently first trials of measuring against service standards.

Communicable disease prevention & control	• non-vaccine preventable diseases • vaccine preventable diseases • outbreak investigation & management
Non-communicable disease prevention	• healthy beginnings program • early childhood program • modifiable risk factor reduction
Public health enhancement	• school-aged children & youth • community health promotion fund • community social supports

CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

LONG TERM CARE

Long Term Care core services are in draft form only and have not been endorsed by the Long Term Care sector nor the Department of Health.

Assessment	
Placement	
Case Management	
Service Delivery (with referrals as appropriate)	• health enhancing services • diagnostic & treatment services • continuing care services • therapeutic, diagnostic and support services • supplementary services

CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

HOME CARE

Standards have been identified and are measured on a regular basis.

Assessment	
Case Management	
Referral	
Service Delivery	• nursing care • personal care • home support • oxygen therapy

F/coreservicestables
Nov 8/99 MMc

OVERVIEW OF ACUTE CARE SERVICES IN NOVA SCOTIA

Work in Progress

Elizabeth Barker, Director
Acute Care Programs Section
Nova Scotia Department of Health
November 23, 1999

Prepared for:
N.S. Provincial Health Council

Overview of Acute Care Services in Nova Scotia

This document is intended to provide:

- an understanding of the range of acute care services
- template identifying the various levels and types of acute care services currently provided in Nova Scotia for residents of this province and in certain circumstances, to residents of the Atlantic Province's *(Appendix 1)*
- outcomes which may be expected from the acute care sector
- a Glossary of Terms commonly used in the provision of Acute Care *(Appendix 2)*.

Acute Care Programs and services in Nova Scotia Hospitals must comply with the requirements of all relevant federal and provincial legislation, as well as with all prevailing provincial policies and procedures. The Canada Health Act is an important piece of federal legislation affecting the delivery of health services in all Canadian provinces. Medically necessary services provided through hospitals are insured.

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All facilities providing acute care services and programs are expected to comply with the standards, guidelines and/or requirements of the CCHSA (Canadian College on Health Services Accreditation), and related Department of Health Policy Releases.

1. SCOPE OF ACUTE CARE

Acute Care

- involves active interventions to reduce the impact of urgent or life-threatening conditions or injuries
- is generally episodic and short term in nature
- includes the full continuum of prevention, assessment, diagnostic, emergency, treatment, rehabilitative and palliative services
- includes obstetric, pediatric, perinatal, mental health, medical and surgical services
- is delivered by physicians, nurses and many other health care professionals and community workers

Acute care has traditionally been associated with in-patient hospital beds. However, many of these services can today be provided on an out-patient basis, in a physician's office, in a community health centre, in an emergency room or at home. As Nova Scotia moves towards a more community-based health care system, with an emphasis on quality of life and evaluated outcomes, acute care must be delivered in ways which involve the least possible intervention or loss of independence for the individual. The services offered must be **efficient, effective, appropriate, accessible** and **acceptable** to individuals and their families.

In the years ahead, the major functions of the hospital are likely to be the delivery of ambulatory services, diagnostic imaging, laboratory services, high technology interventions and the management of emergency and serious illness.

Definitions of Acute Care

The various levels of specialization in acute care are defined as **primary, secondary** and **tertiary** care.

Primary Acute Care

Primary acute care is provided by the health care professional first contacted by the patient. The types of primary services include low risk obstetrics, pediatrics, geriatrics, mental health, emergency, medical, surgical, rehabilitative and palliative care, provided by the most appropriate, qualified health care provider. Primary acute care is provided to individuals who require diagnosis, treatment and other service which assist in promoting health, preventing disease, rehabilitation or convalescence, or support in a peaceful death.

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Primary acute care services can be delivered at home, in a physician's office, in an ambulatory setting, in clinics, in a community health centre, in an emergency room and in all hospitals. Primary acute care should be provided as close to home as possible.

Secondary Acute Care

Secondary acute care services include more complex diagnostic and treatment services provided by physicians and health care professionals with specialized training. Diagnostic and treatment services are provided on referral from primary care service levels. Secondary care can be available to individuals either within their region or another region.

Tertiary Acute Care

Tertiary acute care refers to sophisticated diagnostic and treatment services which are provided on referral from physicians and other health care professionals. Tertiary care is provided to patients with overwhelming illness and/or complications.

Tertiary care services:

- should be accessible to all residents with complex needs or medical conditions;
- require a large population base to maintain professional expertise and competence, as well as cost-effectiveness of service provision;
- require sufficient, highly specialized physicians and health care providers to support this level of care;
- entail extensive interdisciplinary teamwork;
- require sophisticated supports in terms of facilities and equipment.

Examples of tertiary care services would include open heart surgery, radiotherapy, neuroscience, neonatal and pediatric intensive care, high-risk antepartum obstetrics, etc.

Other highly specialized, tertiary care services may be available within Nova Scotia, or provided in another province through the appropriate inter-provincial arrangements. Examples would include bone marrow transplants, organ transplants, specialized and highly sophisticated diagnostic or treatment procedures and equipment. Tertiary care should be accessible to all residents of the province.

2. GOAL OF ACUTE CARE SERVICES

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The goal of acute care will be to create an integrated system of acute care services where quality of care is the focus, based on a coordinated, accessible and acceptable network of referral starting at the community level. Acute care is an equal partner in the continuum, where quality of life and evaluated outcomes will guide decision-making.

A focus on outcomes is fundamental to acute care services. Acute care should be planned to meet regional needs, enhance health, improve quality of life, maintain the most optimal level of independence and ensure maximum cost-effectiveness.

Together the Department of Health and the appropriate stakeholders will work to develop indicators of **effectiveness, efficiency, appropriateness, acceptability,** and **accessibility** for assessing acute care service delivery.

Key questions for consideration will include:

Effectiveness

- Does the treatment or service help to produce measurable increases in survival or quality of life?

- Measures of effectiveness include **morbidity (death) and mortality (complication), technology impact assessments, level of functioning, patient surveys, and outcome screen audits and current research.**

Efficiency

- Were the fewest possible resources used (including time, tests, equipment and facilities) in achieving the outcome? Measure of efficiency, for example, include **cost per case, length-of-stay, care mapping, drug utilization review, percentage of surgery** that is classified as same day surgery, etc..

Appropriateness

- Was the treatment necessary and was it the right intervention? Measures include: **practice variation rates, current research, practice guidelines, standards.**

Accessibility

- Was the service provided in the right place and at the right time? Measures include **referral rates, waiting lists,** etc..

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Acceptability

- Have the patient and family members been allowed to make an informed decision and given information about all alternatives? Measures include: **patient satisfaction surveys, consent procedures and education tools.**

Safety

- Was the service delivered in a way that was safe for both the client and the caregiver? Measures include: **patient satisfaction surveys, adherence to safety guidelines.**

Provider Competence

- Was the caregiver competent when delivering the service? Measures include: **monitoring of adherence to service standards.**

Continuity of Care

- Was there consistency of care so that clients benefited from a continuum of care without barriers or interruptions? Measures include: **patient satisfaction surveys.**

3. EXPECTED OUTCOMES

Acute care services should strive to achieve the following outcomes:

- Enhanced quality of service with the best possible patient outcomes.
- High quality of care with effective evaluation mechanisms for clinical care and service delivery;
- Hospitals as centres of excellence with a focus on client-centred care not beds;
- Improved use of existing acute care beds, including a shift from inpatient to outpatient care; utilization management will be integral to all acute care services;
- Strengthened linkages between institutional facilities and community agencies;
- Bed capacity congruent with appropriate use and need;
- Services rationalized according to an evidence-based decision model;
- An affordable and sustainable rate of growth in acute care services.

Work in Progress

From Eliz Barker

APPENDIX 1 LEVELS & TYPES OF ACUTE CARE SERVICES

SERVICES	PRIMARY/ COMMUNITY	SECONDARY/ REGIONAL	TERTIARY/ PROVINCIAL
Surgery			
✓ • Cardiac			x
✓ • General	⊕	x	x
✓ • Urology (incl. Lithotripsy)		⊕	x
✓ • Neuro			x
✓ • Reconstructive & Plastic		⊕	x
✓ • Cardiovascular			x
✓ • Orthopaedics		x	x
✓ • Oral & Maxillofacial		⊕	x
✓ • Organ Transplantation - Surgery - Followup	 	 ⊕	 x x
✓ • Vascular & Thoracic		x	x
Anaesthesia ✓		x	x
Medicine			
✓ • General	⊕	x	x
✓ • Cardiology		x	x
✓ • Endocrinology			x
✓ • Oncology - Medical - Radiation		⊕ ⊕	x x
✓ • Nephrology			x
✓ • Ophthalmology		x	x
✓ • Neurology		⊕	x
✓ • Pain Management	⊕	x	x
✓ • Haematology			x
✓ • Gastroenterology		x	?
✓ • Respirology		x	x
✓ • Rheumatology			x

Work in Progress

SERVICES	PRIMARY/ COMMUNITY	SECONDARY/ REGIONAL	TERTIARY/ PROVINCIAL
Medicine			
• Family Medicine	x	x	x
• Dermatology		⊕	x
• Immunology			x
• Otolaryngology		x	x
• Infectious Diseases			x
Obstetrics			
• High Risk		x	x
• Low Risk		x	x
• Routine Pre & Postnatal Care	x	x	x
Gynaecology			
• General		x	x
• Oncology			x
Pediatrics			
• General	⊕	x	x
• Growth & Development			x
• Clinical Immunology & Allergy			x
• Pediatric Oncology			x
Intensive Care			
• Medical/Surgical/Critical/Cardiac		⊕	x
• Burn			x
• Neonatal/Pediatric		⊕	x
Diagnostic			
• Radiology		x	x
• Mammography Screening	⊕	x	x
• Imaging			x
• Phlebotomy Services	⊕	x	x
• Laboratory Medicine		x	x
• Medical Microbiology		⊕	x

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SERVICES	PRIMARY/ COMMUNITY	SECONDARY/ REGIONAL	TERTIARY/ PROVINCIAL
Occupational Therapy	⊕	x	x
Physiotherapy	⊕	x	x
Pathology		x	x
Emergency Services			
• Level 3		⊕	x
• Level 2		x	
• Level 1	⊕		
Rehabilitation		⊕	x
Prosthetics			x
Palliative Care	⊕	x	x
Dentistry	⊕	x	
Restorative Care		x	x
Geriatrics		x	x
May Also Include:			
• Bone Marrow Transplant			x
• Genetics			x
• Pediatric Growth & Development			x
• Dermatology/Laser			x
• Sleep Disorders			x
• Speech Language Pathology			x

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Key: x = must be provided
⊕ = may be provided when feasible, according to requirements of quality service, resource availability, critical mass, etc.

Note: 1) Many secondary/regional services are also provided at tertiary facilities in Nova Scotia. There are a number of reasons for this, including the scope of the hospital's role in providing care to its catchment population; the care needs of patients with "multi-system" clinical problems; etc.
2) The above list is neither exhaustive nor comprehensive. A number of sub-specialty clinical programs' services are not included.

APPENDIX II GLOSSARY OF TERMS IN COMMON USE IN ACUTE CARE

Academic Health Science Centres
Hospitals with formal university affiliations which have major research initiatives provide substantial training for medical students and other disciplines at both undergraduate and postgraduate levels, and provide a comprehensive array of significant tertiary care programs on a regional basis.

Acute Care
Care or treatment for illness or injury requiring concentrated attention by health care workers, usually for a short period of time.

Affiliated Teaching Hospital
A hospital with an affiliation agreement with the University, indicating compliance with Royal College criteria.

Ambulatory
Walk-in care not requiring an overnight stay in hospital.

Anaesthetics
A term for the group of drugs or agents that produce the state of anaesthesia (partial or complete loss of sensation) and for the medical discipline concerned with their administration.

Angioplasty
A technique for treating narrowing or blockage of a blood vessel or heart valve by introducing a balloon into the constricted area to widen it.

Anomaly/Anomalies
A deviation from what is accepted as normal, especially a birth defect (i.e., a limb malformation).

Audiology
Clinical diagnosis and treatment of hearing loss (study of hearing loss).

Cardiac Catheterization
Passage of a long, fine catheter through a blood vessel into the chambers of the heart as an aid in diagnosis and treatment of various heart disorders and anomalies.

Cardiovascular
A term that means pertaining to the heart and blood vessels.

Care Maps
Flow charts to guide provision of health care to, and anticipated response of, patients with specific disease conditions.

CAT Scan
An abbreviation for computerized axial tomographic scanning, more commonly known as CT Scan. It is a diagnostic technique in which the combined use of a computer and X-rays are passed through the body at different angles to produce clear cross-sectional images ("slices") of the tissue being examined.

Clinical Protocols
Systematically developed statements to assist practitioners and patients with decisions about appropriate health care for specific clinical circumstances.

Community-based Care
Health care services provided to individuals and families by non-hospital-based agencies such as home care, public health or community health centres.

Consolidation
The bringing together of programs or organizations into a single site or entity.

Critical Mass
The optimum threshold for levels of service delivery at which resources are efficiently utilized (under which resources are not efficiently utilized).

Cystic Fibrosis
An inherited disease, present from birth, characterized by a tendency to chronic lung infections and inability to absorb fats and other nutrients from food.

Dermatology
Concerned with the skin and the disorders that affect it. Also included are the hair and nails together with their various disorders.

Diagnostic Services
Services supporting the diagnosis of disease (e.g., laboratory, imaging).

Dialysis
A technique used to remove waste products from the blood and excess fluid from the body as a treatment for kidney failure. There are two methods of dialysis: hemodialysis, which filters out wastes by passing blood through an artificial kidney machine; and, peritoneal dialysis which filters wastes via a catheter inserted into the abdomen.

Work in Progress

Effectiveness
Probability of benefit to patients from a specific medical service under average conditions of use.

Efficient
An effort produced with the least expenditure of resources

Elective Surgery
Optional, not necessarily urgent surgery.

Emergency Services
Care provided to emergent or urgent walk-in patients, who are not admitted immediately after the encounter. For example, ER patients (who are not admitted or pre-booked).

End-Stage Care
Palliative care preceding death.

ENT (Otolaryngology)
The specialty concerned with diseases of the ear, nose and throat.

Ethnocultural
Pertaining to race and practices/characteristics of the race.

FTE (Full Time Equivalent)
A measure of hospital staffing resources based on the annual hours of work by a full time employee.

Work in Progress

Geriatric
Pertaining to old age.

Gynaecology
The medical speciality concerned with the female reproductive system.

Haematological Services
Diagnosis and treatment of disorders of the blood and blood forming organs.

Immunology
The study of the immune system.

Inpatient
A hospital admission to and discharge from an inpatient bed, for which an HMRI inpatient discharge abstract is prepared. Typically, the patient remains in hospital for more than 24 hours, but can be less (i.e., some sign-outs, transfers, deaths may have a length of stay of zero).

Laparoscopic Surgery
A method of directly examining the interior of the abdomen by means of a laparoscope (viewing instrument and repairing/removing tissue.

Length of Stay (LOS)
The amount of time, usually measured in days, spent by a patient in hospital.

Levels of Care (Acute)
Categorization of care according to degree of medical and/or technological specialization normally required (e.g., primary, secondary, tertiary).

Magnetic Resonance Imaging (MRI)
A diagnostic technique that provides high quality cross-sectional or three-dimensional images of organs and structures within the body without using X-rays or other radiation.

Median Length of Stay
The point above and below which 50% of patients' length of stay fall.

Metabolic
A term pertaining to the chemical processes that take place in the body. Metabolic disorders are a group of disorders in which some aspect of the body's internal chemistry is disturbed.

Minimally Invasive Surgical Technology
An advance in surgical techniques characterized by small incisions and use of lasers or micro-surgery, leaving minimal scar tissue and requiring shorter recovery time.

Musculoskeletal Services
Diagnosis and treatment of disorders of the skeletal and muscular systems of the body.

Neonate
An infant under the age of one month.

Neonatological Services
Care of newborn infants and the diagnosis and treatment of disorders or newborn infants.

Nephrological (Nephrology)
Concerned with the normal functioning of the kidneys and with the causes, diagnosis and treatment of kidney disease.

Obstetrics
The branch of medicine concerned with pregnancy and prenatal care, childbirth, and postnatal care. Obstetrics also involved the study of the structure and function of the female reproductive system. There is thus an overlap with gynaecology and most Obstetricians are also Gynaecologists.

Occupational Therapy
Therapeutic use of work, self-care and play activities to increase independent function, enhance development and prevent disability.

Oncologist
Physician specializing in the study and treatment of cancer.

One-Day Care/Day Surgery
A hospital encounter between three and 24 hours duration, which typically involves a surgical, diagnostic aor therapeutic procedure. Examples include day surgery, endoscopies and cystoscopies.

Ophthalmologic Services
Diagnosis and treatment of disorders of the eye.

Orthopaedic
The branch of medicine dealing with the ear and its diseases and the branch of medicine which has to do with the throat, pharynx, larynx, nasopharynx and tracheobronchial tree, and which together are regarded as a single speciality.

Outpatient
Care provided to a patient that does not necessitate admission of the patient to an inpatient bed.

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Outreach Education
Services provided in the community, but not in a person's home, including community education sessions. Examples include pre-natal classes, prevention and health promotion seminars.

Palliative Care
Interdisciplinary care for the terminally ill, that aims to comfort and support the patient and family through the process of dying by addressing the range of physical, psychological, social, spiritual and economic needs.

Paediatrics
Care, diagnosis and treatment provided to children between the ages 0-16, and in some cases, up to 18 years of age.

Physiatry
Specialized rehabilitation services provided by physicians trained in physical medicine.

Physiotherapy
Treatment by physical and mechanical means, as massage or electricity to promote wellness, independent lifestyles, optimal health and movement.

Post-Traumatic Deficit
A physical or psychological condition that follows or results from physical injury or a severe emotional shock.

Primary Care (Acute)
Care provided by a health care worker on a patient's first contact with the health care system. Primary care may include referral to more specialized levels of care.

Quaternary Care
(term not used in Nova Scotia)
Highly specialized tertiary services usually available in only a single site service a large urban population (e.g., heart, lung or liver transplants).

Rehabilitation
The provision of time-limited therapeutic services geared towards the restoration (optimization) of health, physical or other ability.

Adult Specialty/Tertiary Care
Patients with very complex needs requiring greater medical and professional expertise than required by patients in other streams.

Renal
A term meaning related to the kidneys.

Respite Care
Care offered to provide short-term relief for families collaborating to provide continuing care in the community for family members.

Rheumatology
The branch of medicine concerned with the causes, development, diagnosis, and treatment of disease that affect the joints, muscles and connective tissue.

Same-Day Surgery
Surgery completed in a short time that allows a patient to return home without an overnight stay in hospital.

Secondary Care
Care provided by a specialist health care professional, such as a psychiatrist or general surgeon, on referral from a primary care physician.

Short-Stay Medical Cases
Hospital inpatients with no surgical interventions who stay three days or less.

Speech Language Pathology
The evaluation, management and treatment of adults and children with communication and swallowing disorders.

Tertiary Care
Care that requires highly specialized skills, technology and support services. Usually provided in facilities serving a large region or the province as a whole (i.e., coronary bypass).

Therapeutic Services
Services provided to patients to treat disease.

Transitional Care
Convalescent care provided to support transfer of patients from acute care to home or other place of residence.

Urological
Concerned with the structures, functioning and disorders of the urinary tract in males and females, and of the reproductive system in males.

Vascular
Relating to the blood vessels.

Work in Progress

Addictions Services
Core Services

All services of Addictions Services are part of a continuum of care which ranges from prevention and community education, consultation, intervention, assessment, withdrawal management, structured treatment, community based outpatient service, to sheltered options. The service meets the client needs based on assessment. The linkages provide efficient delivery of a range of community-based services which are readily accessible. There is a strong link among programs for alcohol, drug and problem gambling. Unique differences also exist, but these are best addressed within the framework of addictions and dependency.

Community-Based Services are often the first point of contact with Addictions Services. Services include assessment, intervention, withdrawal management (day program), therapy/counseling and structured treatment (modular programs). Service is delivered through satellite offices (33). More structured intensive treatment services are provided through the Regional Services.

Assessment often begins with a brief screening process which may be done by telephone. If recommended for treatment, a more comprehensive assessment is undertaken. The objectives are: to provide an accurate and thorough understanding of the factors related to substance abuse and problem gambling on an ongoing basis to enhance commitment to change and effectively negotiate the treatment plan among the client, significant others and the treatment team.

Intervention is a specialized process where a caring family/friends intervenes to break the destructive progression of an alcohol/other drug /gambling harmful involvement or addiction. Clinical staff support this process.

Withdrawal management (day service) is an active treatment service which supervises the clinical aspects of drug withdrawal and encourages the client tc continue the treatment process with less than 24 hour a day supervision.

Therapy/counselling is defined as providing information to clients relevant to their change needs, assessing commitment of clients to goals, processing thoughts and feelings with clients that guide change and making referrals that break barriers to achieving treatment goals.

Structured Treatment Modular Programs focus on strengthening the client's personal coping skills; providing basic information on addiction and its physical, emotional, cognitive, and spiritual effects; and exploring feelings, attitudes, self esteem, and personal growth issues in a supportive environment. Modular programs are easily portable and conducive to delivery in the community.

Regional Services are offered through eight major sites. The regional service may act as the community-based service for the immediate geographic area. Regional services also provide more structured intensive treatment services, including withdrawal management (inpatient), structured treatment, long term sheltered and halfway sheltered options.

Withdrawal management is an active *inpatient* treatment service which supervises the clinical aspects of drug withdrawal and encourages the client to continue the treatment process. The inpatient withdrawal management component focuses on the client whose physical and emotional state requires extensive intervention into their own environment.

Structured treatment (treatment orientation) is offered to people who have successfully completed a withdrawal management process. Objectives include provision of basic information on addictions and insight on individual effects through exploration of feelings and attitudes in a supportive environment.

Structured treatment (rehabilitation program) provide a step beyond treatment orientation for clients who may require an extended period of treatment education, support, self-exploration, and coping skills development.

CORE is a combination of treatment orientation and rehabilitation programming in the Central Region designed specifically to meet the individual client needs within an environment with a large volume of clients residing in close proximity to the service delivery site. It is a day service with residential support when required.

Halfway sheltered environment options serve a small segment of the population. The objectives are to be a transitional facility in the community, providing residential accommodation in a group setting and assisting the recovering dependent person to extend his/her period of abstinence. Facilities are not located in all Regions although clients are accepted from all areas of the province based on the availability of space.

Long term sheltered environment options serve a small segment of the population. Objectives are to provide a setting and environment conducive to long term rehabilitation. Facilities are not located in all Regions although clients are accepted from all areas of the province based on the availability of space.

Targeted Services are designed for segments of the population identified as having specialized needs. Specific programs and services may not be offered within each region or community though they are available to all Nova Scotians.

Choices Adolescent Addictions Program delivers an outpatient and intensive day treatment service for adolescents and their families. Portable modular programs can be delivered in any area of the province. Residential support is offered in Central Region for adolescent clients.

Matrix Women's Services delivers an outpatient and intensive treatment day program for women in the Central Region.

Driving While Impaired - Second Offenders Program is a targeted program directed in cooperation with the Department of Business and Consumer Affairs - Motor Vehicles Division for individuals convicted of a second impaired driving offence. This service is offered throughout the province.

Prevention and Community Education targets the individual, family and community in responding to identified issues. Services include health promotion, education, training of allied professionals and community development. Volunteers, including Local Committees on Drug Awareness, are instrumental in the implementation of information and awareness programs.

Health promotion programs provide a broad range of information to a wide range of individuals, families and communities. Addressing identified needs, the goal is to raise the level of knowledge and encourage and support a positive, low risk lifestyle.

Education programs seek to influence a positive change in participant's attitude and/or behaviour.

Training programs focus on influencing a change in participant skill and behaviour.

Community development fosters a change in attitudes and/or behaviours within communities or identifiable populations. The process is based on a cooperative problem solving approach by relevant stakeholders utilizing community resources.

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November 24, 1999

CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

ADDICTIONS SERVICES

Addictions Services core services developed with the field and drafted in 1997.

Prevention & Community Education	• health promotion • education • training of allied professionals • community development
Community-Based Treatment Services	• assessment • intervention • detoxification-day program • therapy/counseling (treatment education) • structured treatment-modular programs
Regional Treatment Services	• assessment • intervention • detoxification - inpatient • therapy/counseling (treatment education) • structured treatment - treatment orientation program • structured treatment - residential and non-residential rehabilitation programs • structured treatment - CORE • long term sheltered environment option • halfway sheltered environment option
Targeted Addiction Services	• adolescent treatment • women's addiction services • driving while impaired - second offender's program

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Primary health care
Community-based health care/services
Primary care

The various interpretations of the above terms could easily be considered a reincarnation of the Tower of Babel experience! Various professions and organizations have differing opinions on what the terms mean and some use them interchangeably. There have even been recommendations arising from national consultations for a national clarification of these terms.

PRIMARY HEALTH CARE
(The broadest of the three terms, which encompasses the others)

For our purposes, we should consider this the umbrella term which encompasses the other two. The term "care" is misleading, because "primary health care" specifically refers to a determinants of health approach, much of which is not based on "care' at all, but on environment, poverty, education, etc. (see page 3 in Background Reading material). Primary care services are, however, very much a part of primary health care.

The most widely accepted definition of primary health care is the World Health organization's definition; however, there is considerable variation in its interpretation.

Primary Health Care:

> Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford. .. It forms an integral part both of the country's health system, of which it the central function and main focus. and of the overall social and economic development of the community. It is the first element of a continuing health care process... Primary Health Care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative (and supportive) services accordingly.

From World Health Organization Alma-Ata Declaration (1978) Geneva.

A short form, used in the glossary prepared for Community Health Boards, states that Primary Health Care is "A belief that health is determined by all aspects of a person's life rather than by the health care services provided to them."

COMMUNITY-BASED HEALTH CARE

A component of primary health care, representing those services, including primary care, that are-or should be- available in the community.

Given there has been no provincial process to define community-based health care, this term can be considered to include all those health care services that are, or should be available in the community. This would include primary care (see below) as well as a broad range of treatment, diagnostic and therapeutic services, including - but not limited to-: level 1 emergency care, home care, long term care, primary level obstetrical care, physiotherapy, occupational therapy, basic laboratory and diagnostic imaging, respite care, public health services, addictions services, mental health. (Some of these are also considered by some to be apart of primary care.)

PRIMARY CARE

The following definition was developed through consultation with stakeholders, and yet still is not well understood. It encompasses those services typically offered by a family physician, but also includes some elements of public health, home care, long term care, primary level obstetrical care, primary mental health, etc.

> For the purposes of the Strengthening Primary Care Evaluation Initiative, primary care is defined as the individual's or family's initial and continuing contact with the health care system. Primary care services include health promotion and disease prevention, acute episodic care, continuing care of chronic conditions, education and advocacy.
>
> Examples of publicly funded primary care services provided in communities include home care, long term care, public health, family physician's services, emergency health, palliative care, addiction services and community mental health services.

From Strengthening Primary Care an Evaluation Initiative (Background Document, April, 1999). Nova Scotia Department of Health Primary Care, 1999, p. 5

Prepared for PHC Core Services Advisory Committee, Nov. 25/26, 1999
Harriet McCready, Director, Primary Care, DOH

From Harriet McCready

CORE SERVICES IN NOVA SCOTIA'S HEALTH SYSTEM

PRIMARY CARE/COMMUNITY-BASED HEALTH CARE

Primary care is the core service that should be provided at the community level.

Other community-based health care services may include:

- Level 1 emergency care,
- Continuing care (home care, long term care),
- Primary level obstetrical care, (pre-and post natal)
- Physiotherapy,
- Occupational therapy,
- Basic laboratory and diagnostic imaging,
- Respite care,
- Public health services,
- Addictions services,
- Mental health.

(Note: In some jurisdictions, and among some professions, some of the above are also considered by some to be apart of primary care.)

Core Svcs given out by
DoH staff @ Advisory Committee
mtg, Nov 1999.

Nova Scotia's Health Goals

- ***Health Promotion: Promote and improve the health of all Nova Scotians.***

  While continuing to provide quality health care, we will shift our emphasis to the promotion of health and the prevention of illness, disability, and premature death.

- ***Healthy Environment: Make Nova Scotia a safe and healthy place to live.***

  To be healthy, we need clean air water, and soil, as well as safe places to live, work, and play. We will restore, protect, and develop our environments to support health.

- ***Healthy Living: Support the efforts of individuals, families and communities to lead healthy lives.***

  We will support each other in our efforts to understand the factors that affect our health and take responsibility for those things we can control.

- ***Management: Ensure that the resources needed to support health are managed wisely and fairly.***

  Our taxes pay for the people, programs, equipment, and facilities that support health. These and other resources will be used in ways that are open, effective, efficient, and accountable.

- ***Participation: Involve Nova Scotians in decisions affecting health.***

  Opportunities and support must be provided for all of us to participate in making decisions about our health and he health care system. All decision makers are accountable to the public for their actions.

- ***Social Justice: Ensure that all Nova Scotians have the opportunity to achieve health.***

  Poverty, unemployment, racism, illiteracy, violence, rural isolation, and other issues make it more difficult for some people to be as healthy as others. The policies we put in place must address these factors that a[illegible] our health.

Things that Affect Your Health

- ***Income and Social Status***
  Greater income & higher social status generally equals better health.

- ***Social Support Networks***
  If you have the support of family and friends you are generally healthier.

- ***Education***
  Higher educational levels lead to better health.

- ***Employment and Working Conditions***
  The more control you have over working conditions and employment, the healthier you will be.

- ***Physical Environment***
  Exposure to harmful physical, chemical and biological agents can damage your health.

- ***Social Environment***
  Social support and isolation, emotional deprivation, stress, learned coping skills all have an impact on your health status.

- ***Biology and Genetic Endowment***
  Your family history of health and illness can affect your own health.

- ***Personal Health Practices and Coping Skills***
  The choices you make about things like smoking, sexual practices, health care practices and diet all affect your health status.

- ***Healthy Child Development***
  The best way to ensure that a group of people is healthy is to make sure that its children have a good start in life. A well nourished, educated and challenged childhood will lead to a healthy adult.

- ***Health Services Available***
  The health services available play a small part in your health status. The health service that most affects the health of a group of people is getting rid of childhood diseases.

- ***Gender***
  Women still live longer than men.

- ***Culture***
  Culture plays a large part in the way we relate to health, illness, the health care system, our lifestyle choices and many other areas of our life.

Appendix 2
Advisory Committee

- 2.1 Pre-Meeting Questionnaire
- 2.2 Summary of Participant Responses to Questionnaire
- 2.3 Participant List
- 2.4 Summary of Advisory Committee Meeting
- 2.5 Evaluation Tool
- 2.6 Evaluation of Session

Provincial Health Council

Core Services Public Consultation

Advisory Committee

Participant Questionnaires

November 25 & 26, 1999

Suite 301
1888 Brunswick Street
Halifax, NS
B3J 3P7

We (the Steering Committee on Core Services, of the Provincial Health Council) would like to get a sense of your thinking prior to the Advisory Committee retreat on November 25th and 26th.

Could you please respond to the following questions and
return your responses by November 22nd at 4:30 p.m.
By one of the following avenues:

fax: 424-0402
e-mail: dowjr@gov.ns.ca
Mail: Suite 301, 1888 Brunswick Street
P.O. Box 2731
Halifax, NS, B3J 3P7

Based on your reading of the enclosed package, and on your own experience and thinking:

1. What do you believe should be core services for
    a. a community

    b. a cluster of communities

    c. the province

2. What services are you not sure about?

3. What's on your mind relative to the task at hand?
    (We'd like to know about any factors that might affect your ability to participate to the fullest. Please describe them in a brief note here.)

Extra thinking question:

4. What questions might you ask of community groups as part of the public consultations?

Please be sure to send in your responses to these questions by November 22nd.

Summary Table of Core Health Services Identified by Advisory Committee members*

* from questionnaires sent in prior to meeting

Service	Community	Region	Province
Community Health Assessment	4	1	1
Health & Community Services Teams (Primary care) • nurses • social workers • physiotherapists • occupational therapists • midwives (1) • community health worker (1)	9		1
Physicians (GPs or Family Physicians and some spec at community level) • pre-natal and post-natal care • pediatric care	6	3 (spec. in Gyn, Paed, Geriatrics)	2
Health Promotion (includes partnerships with Education and Recreation) for such areas as: • pre-natal • post-natal • infant stimulation • breast feeding support • hearing & speech/language • parenting programs • sexual and reproductive health • nutritional counseling • substance misuse/abuse • family planning • mental health • suicide prevention	9	1	2
Health Protection	4	1	4
Prevention and Public Health Services (includes partnerships with Justice, Education, Housing, etc) - at community level • communicable disease prevention • education and prevention of non-communicable diseases	8		2
Community Acute and Chronic Care			1

Regional Acute and Chronic Care • general surgery • orthopedic surgery • anesthesia • obstetrics • urology • physiotherapy • occupational therapy • general pediatrics • radiology • general medicine • women's health and wellness	3	8	1
Specialty services on rotation to regional hospitals			3
Tertiary Acute Care (including both surgical and medical) • cardiac • neuro • thoracic • transplant • oral • reconstructive • oncology • cardiology • nephrology • ophthalmology • hematology • respirology • gastro • rheumatology		1	11
Developmental, Rehabilitation and Support	3	2	3 (specialty)
Respite Care	3		1
Palliative Care	8	3	1
Home Based Care	9	2 (single entry)	2
Residential Care / Long Term Care	5	1 (single entry)	2

Mental Health Services (includes Education) - at community level: • assessment • self help • early intervention • forensic services (provincial only)	5	5	4 (specialty)
Substance Misuse / Addiction Services	4	5 (if not in community - 1)	1
Diagnostic Services (Lab & X-ray, etc)	7	3	2
Emergency Services - (vehicles at community level - 1) - (response teams -1))	8	4	3
Children's specialty services			2
Policy and standards development for • health promotion education • health protection • prevention and community health services • treatment, emergency & diagnostic services • developmental & rehabilitation support services • information management (1)		1	6
Respond to public expectations and needs: • to increse imphasis on prevention and early intervention • to meet the needs of vulnerable populations • to improve communications and tear down silos • to develop stronger partnerships • to be more accountable			1
Environmental health		1	
Care Coordination (Case management)	1	1	1
Dentistry	3	1	
School health	2		
Youth health centres	1		
Elderly health centres - includes continuum of care for elderly)	1		
Cancer Care		1	1
Geriatric services	1		
Spiritual care	1		

Pharmacare			1
Poison Control			1

Points to add:
- Lab & X-ray services should be within 30 minutes drive from any community
- involve other community groups (garden clubs. etc)
- coordinated communication is important at the community level
- CHBs revisit Health Plans every three years
- central outpatient services for specialties should arrange appointment times taking travel time into consideration and coordinating appointments from communities so that car pooling is efficient
- at the regional level have well-persons information session taht rotate throughout the cluster of communities

Support the services outlined in the Department of Health 1996 document (2 comments)

- make sure community services are community driven with elected Boards of Directors working with other stakeholders

- regional services should not revolve around the regional hospital

Services Not Sure About

Research
Health Statistical Information
Complementary Medicine
Telehealth
Dentistry
Waste products
Reaching the very poor & illiterate

- Does every community or cluster of communities need all the services? If we had a coordinated effort & health community services and education, could not teams cover a proportion of the province for education and promotion?

- Where does corrections and youth services belong?

Where does child welfare belong

Why are some long term care facilities with Community Social Services and others with Health? Does the right had know what the left hand is doing? Causing a duplication of services — or gaps in services.

The utilization of "Care Centers" in Cumberland County, (area 5), as interim holding centers for recovering patients; i.e. The S.C.C.C. in Parrsboro, the Bayview CC in Advocate, The North Cumberland CC in Pugwash and The Highland View CC in Springhill. Can these Centers have their level of care raised so that patients can complete their recovery in their home area, rather than their relatives has to commute many miles to visit them or stay with the patient?

Those services provided at the provincial level and regional level that depend on critical mass and those which are beyond the scope of specialists at the regional level.

"Accessible" - accessibility needs to be defined by time — There needs to be assurance, depending on the seriousness of the suspected condition or the need for specific treatment, that any patient in Nova Scotia will be able to "access" the necessary service within a week, two weeks...

Single entry point (how it will operate and where from. The rural experience with the current ambulance services indicates huge gaps of knowledge when dispatching ambulances. A single entry system, ideal in its concept has to maintain its integrity throughout the province.

What kind of Evaluation and assessment ment of services based on results planning are in place? What are existing benchmarks? How do we move principles of wellness into all services? How do we accentuate prevention, and take into account social/economic conditions — as a result create healthier individuals/communities and decrease health care demands?

- childrens care
- screening services
- oncological services at the local level
- post surgical care at the local level
- public health at the local level (preventative & promotional)

- agency coordination (health/social services/environment/recreation)

- diagnostic services for regional/district vs. Provincial
- technology changes and costs will determine provincial / regional split to some extent re services

- dentistry as a tertiary level care service (does this mean Oral Maxillofacial)
- the distinction (or lack of) between secondary and community

- any service which is an insured service under the Canada Health Act is a core service by virtue of being insured. I see little value in listing all the medical sub-specialty services. They are available based on provider availability and critical mass to support such care. The master plan should settle that one once and for all. Let's not debate it under core services.

- family medicine - should we have this in tertiary facilities in Halifax? I think there is a growing consensus to support this.
- Neurosurgery - sin some circumstances in secondary services. I don't think this is appropriate given the size of the population

- educational component in schools

3. What's on your mind relative to the task at hand?
We'd like to know about any factors that might affect your ability to participate to the fullest. Please describe them in a brief note here.

Answer #1

The first question that comes to mind is "Do I have enough information to comment on the Advisory Committee?"

I have the tendency to be very thorough and very conscientious.

This is an enormous task and I take it very seriously - to represent the whole of the western region seems very challenging.

The above will not affect my ability to participate but I feel you should be aware of my feelings.

Another question is "Will I be required to go to all of the community meetings in Jan.-Mar.?"

Also, will the meeting be canceled if the weather is poor?

Answer #2

I have great concerns regarding time lines and the opportunities for public consultation. Are CHB's being set up to fail as they assist in the public consultation process? From experience we know that unless the house if burning or the thought that there may be a hospital closure, public meetings don't work - we need more time to arrange many different approaches to record public input.

Answer #3

- Why are we undertaking seismic changes in our delivery of health care when the weaknesses of regionalization have not been identified. Nor have the regional "efficiencies," which the department intends to protect, have not been identified.

- Reference to U.S. medical models (i.e., Oregon) are disturbing.

The factor that would most affect my ability to participate concerns phrasing in Future Direction document that seems to suggest the secondary or level two care will be available at the designated district hospital. There are other hospitals (e.g., Inverness Consolidated Memorial) that offer, and we expect will continue to offer general surgery, rehab, respiratory, lab services, diagnostic imaging and several other services associated with acute care. The phrasing would need to allow for hospitals where acute services are offered.

Answer #4

In general, I am quite pleased with our present set-up, except that we are constantly up against financial restraint. I feel that we have cut back as far as we can go. Even with a great army of volunteers we still can't provide the full service that we are equipped to do, and recruitment of professional staff to come to remote places like Yarmouth is difficult to keep a full complement. This applies also the general physicians, we cannot seem to get enough so that all our residents can have a family doctor to see. This shortage has contributed to the large number of patients who have to use the emergency department to get any help.

Another concern that I have is that with approximately 25% of our beds now tied up with patients awaiting long-term care in a nursing home, we are having to cancel elective surgery. What really disturbs me is that the year 2000 is the year that the baby boomers start reaching senior age and that we are in no way prepared for the kind of influx of elderly patients that at our very doorstep. Unless we start building new large facilities for the elderly infirm, we have only two alternatives left. 1. We prepare enough staff to be able to provide an adequate, trained team of home care workers. Even now we don't have enough, nor the funds to provide enough. 2. We lighten up on the extremely tough regulations for smaller long-term care homes, e.g., we all would like to see every facility with full sprinkler system, but what's more important: having a home for long-term care or not having this home. We don't have sprinkler systems in our residences - not even in all apartment buildings.

At the community level we have numerous volunteer organizations that are trying to meet the need of making our community a healthier place in which to live, and also, our Community Health Boards are trying to establish volunteer programmes that will make better health by promoting a better lifestyle. Funding for this type of programme is also difficult to get on a sustained basis. Too often we get start-up funding only to see a good programme close because funding is pulled.

Answer #5

I have some beliefs that will impact on my participation:

- Accessibility to services is a big issue for many people.
- Many people still want what they had before regionalization took place. More hospital beds and more services in their particular community...such as certain medical specialists regardless of how much work there is for them.
- Specialists do not need to be situated only in Halifax. Some should be serving clusters of communities but in some instances their practices will need to be restricted because of the support services they require.
- Every person has a right to the best possible care as close to their home community as is reasonably possible - that may mean in Halifax.
- The standard of care should be the same across the province.
- If a speciality service is offered in an area provision must be made for replacement during the practitioner's absence.
- Clear definitions of primary and secondary care are important for discussion.

Probably the most difficult part will be in establishing a good working relationship amongst the participants. Each person brings their own beliefs and values to the table and conflicts will need to be managed. There is a need for all the cards to be on the table, so that we don't waste our time or energy fighting battle that have already been decided.

Lastly, the role of Dalhousie Medical School in determining the province's health agenda will need to be discussed.

Answer #6

Our ability to stay focused and come out with a good product.

Answer #7

I am concerned about the possibility of fewer services being supported in the DHA's, creating barriers to access for people outside of Halifax.

Answer #8

Social issues related to access to health services delivery, living conditions - poor, homeless, transition from incarceration to community. Working conditions and promoting and fostering respectful work environment.

Answer #9

At school, we house clients from each of the core services. There are lots of services which I have much to learn from. I look forward to this opportunity. I feel we need to begin with sharing, especially if we are moving toward a full-service school model. Thanks for this opportunity.

4. What questions might I ask of Community Groups as part of the Public Consultations?

a) What do you feel is needed in your community for Primary Care?
b) What would it be if part or all of the cost had to be borne by the user or community?
c) What is your level of satisfaction with the present level of care in your community? (Satisfied, somewhat satisfied or not satisfied)
d) What do you feel is needed/required to fix the/any problem?

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4. Questions for the public Answer #1

(I don't know how large your groups would be or the type of questions you wanted so I have included a few samples.)

What service have you tried to get in the last year and did not receive? Explain.
If you did access a service, how long did it take?
Do you feel the time was acceptable? Why? Explain.

In a Utopian system, what vision do you see for health care in Nova Scotia?

If more health service shuttles were available in your community, would you use them? How often - weekly, monthly, yearly, other?
Would you mind a small fee? $5, $10, other?
(Transportation is a real issue in all rural areas so it may be important to ask a question like the above.)

Do you feel there is enough support after a person has been in hospital? No/ Yes? Explain, examples.

If you are a caregiver, what support could you use? How could this be done?

Is there enough information on "How to stay healthy" in your community? Do you honestly use it? If no, what would you like to know about or see?

Also - ask specific questions based on "assumed" information. If you have the public's attention, you might as well use it.

(If waiting time in GP's office shorter, would fewer people use OPD since they could see MD sooner at office?)

Other questions could be about Lab, Xray.

What core services should be under each of below?
(Suggest: make up blocks of what is identified these 2 days and make 3 of each; also make up a

rating / ranking 1-5 (how important); who to do it; how; timeline; and perhaps dollar figures for each in each area)

PROVINCIAL	CLUSTER/REGION	COMMUNITY

4. **Answer #2**

In an attempt to change our focus - health care system which is really an illness care system -

What services would you like to see in your Community or region - which would make it a healthier place to live?
How can you take responsibility for your own health?

What info and/or services do you need to accomplish the above?

4. **Answer #3**

How does the physical environment factor into identifying core services for our community?

4. **Answer #4**

In meeting with the public, it is important to ask for anecdotal examples of existing services. From speaking with health professionals, my understanding is that , from the Department's point of view, there are several functioning health services. From the people who deliver these health services (home care, for example) and from the patients who receive them, the reports are not so glowing. Community services are being offered in exchange for hospital, beds or nursing staff, but the service often does not meet the need.

It is important to ask participants for their perspective or understanding of health care and health services in their community. It is the experience of our Community Health Board that, despite the Department's focus on prevention and education, people do not see their hospital as a separate entity from community health. Previous experience of hospital cuts replaced by partially delivered programmes encourages public suspicion.

Do you believe that rural Nova Scotians have the same level of access to health care that they had a decade ago?

What do you (the public) identify as core services at the community, district and provincial level?

4. **Answer #5**

How would you prioritise community health issues for youth?

How do we move into preventive aspects?

4. **Answer #6**

I would ask them to consider, as individuals, to volunteer in some aspect of our secondary health care institution, i.e. Yarmouth Regional Hospital.

O would ask of them if they were able to expand a service they are already giving.

I would ask them if they would be willing to establish a new programme to promote better health, either by their own group or teaming up with another group.
I would also ask them what they feel they are missing, or inadequate in our present system of health care.

4. **Answer #7**

Where is the community as a stakeholder?
Will there be meaningful feedback?
Are the needs of the people a priority or does budget dictate needs?
What is the community expectation for service?

4. **Answer #8**

What services they now seek at a community level they feel should be at a community level?, what at a regional level?

4. **Answer #9**

I believe Canadians don't think about the health care system until they need to use it. If it works for them, then they forget about it until the next time they need it.

Therefore, people who come to public consultations are frequently those whose experiences have not met their expectations. While it is important to hear their concerns, suggestions, etc., it is important to remember that those who don't speak are generally happy with it.

I think we need to be careful not to raise expectations. I think we need to remember that we use the system differently depending on our age group.

Perhaps we could ask - if you could have three services in your community, what would they be or if you had no services in your community, what would the first three be?

It is important that people have an understanding of the impact of their recommendations.

4. **Answer #10**

To define the kind of services needed to build healthy people, healthy communities.

Remembering that health intervention like surgery, medicine, etc.: are the least likely to contribute to healthy people/healthy communities. The system already funds those services. Let's identify those activities.

4. **Answer #11**

1. Where would you like to access these core services?
2. Where would be an acceptable access point if this is not possible (referring to No.1)?
3. Are there other core services that we have forgotten?

Provincial
Health Council

Core
Services
Public
Consultation

Advisory Committee

Participant List

November 25 & 26, 1999

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Small Group Sessions

	Community **25 Nov 1999 PM**	**Regional** **26 Nov 1999 AM**	**Provincial** **26 Nov 1999 PM**
REGENCY BALLROOM **Facilitator: Rosemary Donkin**	Sheila Profit Theresa Fillatree Lynn Woolnough Helen Gordon Dr. Bob Mullan Debra Keays-White Sandra Cook Anne Power Norm Chandler Thelma Coward-Ince Jane Farquharson Barb Hart	Sheila Profit Theresa Fillatree Rev. John MacNeil Phillip Hochman Marguerite Rowe Sandra Cook Debra Keays-White Josephine Muxlow Anne Power Sally Johnson Katherine Garden Tom Bird	Dave Logie Thersa Fillatree Rev. Ulric Dawson Fred Smith Sport & Rec Debra Keays-White Brian Wilbur Anne Power Penny MacLeod Marilyn Worth Rick Manuel Merle MacDonald
BELLE ISLE ROOM **Facilitator: Marilyn Pothier**	Dave Logie Rick Nurse Rev John MacNeil Phillip Hochman Linda Hamilton Elizabeth Barker Brian Wilbur Kim MacNeil Josephine Muxlow Katherine Garden Linda Judge John Dow	Dave Logie Rick Nurse Rev Ulric Dawson Fred Smith Sport & Rec Elizabeth Barker Brian Wilbur Kim MacNeil Norm Chandler Marilyn Worth Rick Manuel Barb Hart	Dr. David Rippey Rick Nurse Joy Goudge Frank MacDonald Marguerite Rowe Elizabeth Barker Dean Hirtle Kim MacNeil Lois Hudson Sally Johnson Jane Farquharson Tom Bird
BRITANNIA ROOM **Facilitator: Barb Anderson**	Dr. David Rippey Marg Boak Rev Ulric Dawson Fred Smith Sport & Rec Bill Twaddle Dean Hirtle Lois Hudson Barb Burley Mike Arthur Marilyn Worth Merle MacDonald	Dr. David Rippey Marg Boak Joy Goudge Frank MacDonald Linda Hamilton Bill Twaddle Dean Hirtle Barb Burley Penny MacLeod Jane Farquharson Linda Judge John Dow	Fred French Marg Boak Lynn Woolnough Helen Gordon Dr. Bob Mullan Bill Twaddle Derek Dinham Barb Burley Josephine Muxlow Mike Arthur Thelma Coward-Ince Barb Hart

VANGUARD 1 ROOM **Facilitator: Naomi Mensink**	Fred French Evelyn Schaller Joy Goudge Frank MacDonald Marguerite Rowe Harriet McCready Derek Dinham Penny MacLeod Sara Gorelick Sally Johnson Rick Manuel Tom Bird	Fred French Evelyn Schaller Lynn Woolnough Helen Gordon Dr. Bob Mullan Harriet McCready Derek Dinham Lois Hudson Sara Gorelick Mike Arthur Thelma Coward-Ince Merle MacDonald	Sheila Profit Evelyn Schaller Rev John MacNeil Phillip Hochman Linda Hamilton Harriet McCready Sandra Cook Norm Chandler Sara Gorelick Linda Judge Katherine Garden John Dow

Small Group Discussion # 1

Issues Raised in PreWork Questionnaire Returns

1. Please introduce yourself to the other members of the group, describing the following:
    - Your name and normal working or life role
    - The group you represent (region, community, department, etc.)
    - Your interest in this process

    (Time: 10 minutes)

2. Choose one person from within the group to be timekeeper so that the group works within the time limits.

3. Discuss the questions:
    - What issues do you feel are raised by the responses to the questionnaire?
    - What implications do these issues raise for our process over the course of this meeting?

Small Group Discussion # 2

Core Services at the Community Level

1. Please briefly introduce yourselves to the group.

2. Choose another person in the group to be timekeeper.

3. Discuss your thinking on the following:
    - What services do you believe are core at the community level?
    - What services do you believe are **not** to be considered core at the community level?
    - What services are 'in the gray zone' (not sure if they should be considered core or not)?

4. Develop tentative consensus on the services in each category above you would like to have reported to the large group on behalf of your small group.

    Consensus, for purposes of this work, means:
    - Each person can accept the points chosen, even if it is not your personal favourite.
    - You are willing to represent the points publicly (i.e. to the large group)
    - The points chosen do not violate your principles or values.

Remember, as you work:

- We are considering these from the perspective of the consumer/community.
- We want to work within the Health Goals for Nova Scotia.
- We won't worry about sustainability for now.

Small Group Discussion # 3

Core Services at the Regional Level

1. Please briefly introduce yourselves to the group.

2. Please choose another person to be timekeeper for the group.

3. Discuss your thinking on the following:
    - What services do you believe are core at the regional level?
    - What services do you believe are **not** to be considered core at the regional level?
    - What services are 'in the gray zone' (not sure if they should be considered core or not)?

4. Develop tentative consensus on the services in each category above you would like to have reported to the large group on your behalf of your small group.

Small Group Discussion # 4

Core Services at the Provincial Level

1. Please briefly introduce yourselves to the group.
2. Choose another person to be timekeeper for the group.
3. Discuss your thinking on the following:
   - What services do you believe are core at the provincial level?
   - What services do you believe are **not** to be considered core at the provincial level?
   - What services are 'in the gray zone' (not sure if they should be considered core or not)?
4. Develop tentative consensus on the services in each category above you would like to have reported to the large group on behalf of your small group..

Provincial
Health Council

Core Services Public Consultation

Advisory Committee

Meeting Summary

November 25 & 26, 1999

Suite 301
1888 Brunswick Street
Halifax, NS
B3J 3P7

Advisory Committee
25/26 November 1999
Summary
Wayne Marsh

Issues

What are the standards for accessibility? (travel)
What do we mean by available?
What are our principles?

- timely
- available
- accessible
- working
- high risk?

How do we ensure the links to the next level of care (availability and accessibility)
Need to ensure we keep in mind the health goals and the determinants of health

Significant issues identified in the 1st open session, Thursday afternoon

- Jurisdictional issues can confound progress (discussion centred particularly on Mi'Maq access to health care when the responsible jurisdiction is federal but services are provincial)
- Define core at the community level in two ways:
  - generic (all communities)
  - situation specific
- Standards for infrastructure are needed too
- Flexibility needed around the definition of community (build on neighborhoods, communities within communities)
- Jargon issue. Examples include:
  - services vs. programs
  - resource pools
  - & > government funded in any event
- Funding methods need to change to complement integration
- Evidence base for primary care / community services needs to be different from scientific evidence. Qualitative evidence is valid
- Coordination and integration of core services; you go through one door to access all services needed and there are many doors.
- Outcomes / results-oriented planning (community level will be key)

Public Consultation Thoughts

- We need to use clear, understandable communication (Grade 5 level) in bringing this piece to the communities in public consultation
- Advanced explanation
- Don't raise unrealistic expectations
- Position for results different from current fiscal pressure.

- Context = creating health; —> core services; emphasize outcomes
- Clearly define Provincial Health Council; contrast with government
- Talk about emerging themes (integration/coordination)
- Government commitment to listen: maintain status quo plus relevant change as recommended
  - suggest having Advisory Committee participants and MLA present at public consultation meetings.
- Assurance that government will fully assess the information before changing & change is required at all levels: in open dialogue with broad based learning
- Status quo is not acceptable. — health is everyone's responsibility:
  - every citizen
  - all government departments
- Local groups on hand with good news stories; support for these changes .... Assets to build on
- Drive off of broad themes derived from health goals .... amplifying desired results... what works and refinements and opportunities to change
- Local group's stories (lead to) celebrate progress (lead to) promoting the process
- Show what ratification goals needed in policy decisions, legislation.
- meeting with Minister (of Health) and Deputy Minister, yielding a broad statement of support from government. (We need to be) explicit about how program reviews and budget decisions relate.

Small Group Session
Barb Anderson

Basic Instructions for working on each piece:

1. Introductions: Who you are, your organization/role.
2. We will be coming up with three categories of information for the larger group's attention:
   - illustrations of services that we would consider 'in the box' (core at the community, cluster of communities, and provincial levels)
   - illustrations of services that we would consider not in the box (non core at the community, cluster of communities, and provincial levels)
   - Services we would put in the grey zone for now (we're unsure!), and we'll want to be able to explain the rationale for our suggestions (if asked), and capture burning issues that we'd like the whole group to talk about
3. We want to:
   - Start from the consumer/community-based perspective
   - Make sure our thinking aligns with our Health Goals
   - Forget about sustainability for now.

Instructions for reporting back of small groups for Community piece:

- Note the key points from the "list" of core: points to take back (not entire list)
- Assumptions on which our list is based (what are the underpinnings)?
- Relationship to DOH, Provincial Health Goals?
- Issues
- Any questions we want to hear from the larger group on.

Notes:

- We can influence through this process: PHC identified core services can drive allocation of resources

- There is tremendous commitment
  - We want to be part of the solutions
  - Many mechanisms to implement ideas: we want to be part of the process

- Take it from us: this is not Clusters last stand...it's the beginning stand!

Issues

- How far is it reasonable to ask people to travel to access services.
- Do we really know what's spent on bp/dp?
- DOH morale and energy of those involved in creating health
- Structure around regional hospitals in traditional sense vs. Communities of interest: make sure CHBs are integral part.
- Outcomes critical. Government should consider the bigger picture when writing legislation around DHAs.
- Secondary services might only be available at designated district
- Lots happening at tertiary care facilities that could take place at cluster level: implication for cluster (remember, not every cluster will have the same stuff).
- Birthing issues
- Transportation/Accessibility to Pediatrics, ENT, Eye Care, Geriatrics — look at transportation costs vs. accessibility at the local level
- Funding — effects of grants
  - ▸ sustainability
  - ▸ start up on long enough term to be able to continue
- Communities — keep in mind urban and rural. Issues might differ
- Core SERVICE: language assumes we know what's best; have to take all expertise in community into account, includes values, processes.
- Don't want to lose the individual ideas from this discussion

Services under **Community**

- Family medicine - Drs, nurses, nurse practitioners, midwives (pre-delivery & post)
- Obstetrics: routine pre/post natal care
- Pediatrics - general
- Surgery - minor (remove fish hooks)
- Emergency services for ambulance (helicopters essential)
- Dentistry
- Home Care beyond what exists now (i.e. physio, OT, peds.)
- Physiotherapy / OT: scheduled visits to reduce travel
- Mental Health — access to MH services
- Palliative Care
- Community driven hp infrastructure — support for volunteers
- healthy communities plan to incorporate determinants (lead in a collaborative way) — by the Community Health Boards

- Addictions
- Public Health
- Drug Store
- Diabetes Education Centres
- Youth and Seniors programs
- Recreation Services
- Care giver supports
- Nursing Homes
- Community Development — supported CD structure to gauge and mobilize volunteers
- Support for life skills — parenting, coping
- Stigma reduction for mental health (education around serious mental illness, early intervention
- Collapse under health resource centre (promotes single entry for community resources.) Resources delivered by "patchwork" - consider co-locating resources. Community response to community well-being. Promote wellness.
- Access to geriatric specialties.
- Day Care — child/adult
- Adult Day Schools
- Geriatrics
- Specialized nutrition needs
- Spiritual care
- Rehabilitation following hospital
- Look at schools as a place to deliver services as well as workplace
- At schools — involve everyone in gym vs. competitive sports
- Evidence-based programs, effectiveness demonstrated
- Mechanisms for joint planning (this needs to go beyond community).

Not Core

- Anything requiring expensive outlaying of equipment (MRI, EKG)
- Laboratory services (but place for samples to be taken)

Services under **Cluster of Communities**

- Restorative Care (slower paced rehabilitation) — needs definition
- Geriatric specialists and supports
- General surgery
- Psychogeriatrics (including mental health services for the elderly)
- Lifelong Mental Health (lifestyle, continuum)
- Diabetic Education
- Asthma and COPD: ongoing support and follow-up, with a focus on improvement for risk groups
- Prevention and Promotion based on adult education and community development principles, capacity building
- Education of those people delivering programs
- Progress Rehab

- Diagnostics (will be a consideration around accessibility and economy of scale)
- Public Health Protection (outbreaks of disease, immunization strategies)
- Information system based on capacity building (integrated between the province and the clusters)
- Capacity in cluster of communities to deal with long term effects of mental illness.
- Treatment programs for children, youth, adults for mental health
  - intensive day programs
  - residential care for children & youth
- Capacity building around health promotion/disease prevention
  - identifying gaps
  - coordinated chronic disease care
  - participation in development of standards, resources, coordination
- Spiritual care (needs more clarification)
- Public Health
  - through priority areas
- Addictions
  - detoxification
  - differing ways of implementing
- Emergency health
- Supportive living environments
- (Accepted acute care list as pre-circulated in principle)

Services under **Provincial**

- Standards, goals and objectives for any services
- Research
  - collecting data
  - using data

  Needs to trickle down to manage and monitor
- Policy for an inclusive health care system
- Enabling of diagnostic services at the cluster level
- Use of technology for integration, coordination and implementation. There should be provincial standards (relates to evidence)
- Public Health Protection (outbreaks of disease, immunization strategies)
- Information system based on capacity building (integrated between the province and the clusters)
- Development of health public policy
- Treatment programs for children, youth, adults for mental health
  - acute psychiatric services
  - supports and coordination of standards and practices
- Capacity building around health promotion/disease prevention
  - identifying gaps
  - coordinated chronic disease care
  - participation in development of standards, resources, coordination

- highly specialized critical care (as per sheet)
- Capacity building for our health providers on how to create health
- Public Health
    - standards and research
- Emergency health
- Forensic services

Assumptions/Principles

- Health Goals
- Health determinants
- Definition of health
- Input from people in the community
- Have to deal with an aging population
- Service is offered closest to the consumer taking into consideration economy of scale and quality
- Standards set
- Integration and linkages (at community, cluster of communities and provincial levels and not just with Health) implemented to support a continuum of care (need to ensure ongoing supports for cluster)
- Integration and coordination at the point of entry.
- For many of these services it's not just health of the health envelope. There is a need for a mechanism for integrative supports and services.
- In order to move forward on determinants of health and health goals we have to break down traditions silos, bring collective energies to working for health of IVSs .
- Policy development screened through cabinet
- We tried to limit it to core health , but already this is "mission impossible". We need to support an integrative system.
- Not giving to, doing for or downloading, but creating capacity and infrastructure supports this. It needs to be resourced
- Coordination and integration. What's different — across government, community organizations, nongovernmental groups.
- Didn't focus on disease states. We think that emphasis on core services needs to be based on data indicating what causes chronic disease (big $s going here)
- Healthy public policy: government as a whole — needs to be integrated
- Integration and linkages between community - cluster - provincial **and** among departments, NGOs and community organizations.
- Educate the public re the broader issues and integration. Opportunity for the PHC to raise the issues; hold the dialogue and develop a scorecard to monitor (not from self-interest). (Much thought!)
- Valuing work that's already been done
- increased focus on health promotion and disease prevention
- Legislation and roles of CHBs and DHAs developed, take into account need to develop legislation around broader perspective of provincial health goals
- Need to focus on health promotion and prevention (illness and injury)
- We will involve communities in a meaningful way

Health Goals

Health

Community Core Services

Cluster of Communities Core Services

Provincial Core Services

←→

Education

Justice

NGOs

Recreation

Community Services

Communities

etc.

Outcomes
Accountability
Role of DHAs and CHBs
Role of Government by Design

Challenge is how to integrate/coordinate. How do all fit in a system and structure to achieve goals?

Key Points

- Healthy public policy (not just the responsibility of "health")
- Mechanism for joint planning, education and action around health goals across government/ community groups and organizations/ NGOs — throughout the system (community, cluster, provincial)
- Any program delivered evidence-based
- Adhered to community development principles. Supports for CD
- Respect that all communities are different and therefore have differing assets and needs
- Single entry across the board (beyond current focus on continuing care). Integrated approach.
- Connect to health goals. Informed options.
- Not once did we talk of beds
- How will communities be involved in decisions?

- How to get people to participate? Hold sessions, people don't always come. Have to go to where the people are.
- Community consultations need a preamble about health and wellness.
- Need effective communication
- Need more discussion on single entry.
- To what extent do we hold individuals responsible for their health (ethical and moral issues)

Factors that Determined What was on List

- High risk
- High volume: connected to transportation
- What's traditionally available
- Attempt to be "reasonable"
- Identified gaps on health promotion/prevention side
- Health beyond traditional "care"
- Economic factors
- Need for prevention/ early intervention
- Willingness on the part of the community to be innovative, to try new things (non traditional)
- Aging population
- Accessibility
- Improved coordination, reduce duplication

Small Group Session
Rosemary Donkin

Community Health Board Chairs Input

Core Services should include access to:

- family medicine - family physician
  - nurse practitioner

These professionals need the ability to get support from referral specialists and diagnostic services

- pre and post natal care & education
- gynecological screening (e.g. well women's clinics
- minor surgeries for diagnostic purposes
- general pediatric services
- palliative care - pain and symptom management, home care and volunteer services
- emergency services - assessment and stabilize
- rehabilitation services - both physio and OT
- nutritional and healthy lifestyle programs
- addictions services - partner with education system and RCMP
- Mental Health Services - partner with Education system
- Home care services and family support services
- Public health services and communicable disease services
- crisis intervention

- long term care - focus on health enhancing services
- pharmacy
- continuing care
- A coordinated transportation service
- single entry service
- health promotion programs
- continuing education for health professionals

Group Additions

- dentistry - also for adults
- vision, hearing, developmental and speech screening for children (pre-schoolers)
- mammography screening
- high risk screening (children)
- help line
- grief support groups
- meal programs - adult & children
- geriatric assessment

Programs for:
- family violence
- community housing
- friendly visiting
- recreation harm reduction
  - needle exchange
  - blood born pathogen testing -
- drug rehabilitation
- stress reduction
- smoking cessation
- capacity building
- self-esteem building
- parenting
- protection: environment, infection diseases
- special needs (children)

Focus on:
- outcome measures
- community development (e.g. child care that is safe and affordable)
- supported employment
- asset mapping
- coordination of services
- evidence-based programs
- information data base
- development of protocols that support children and youth
- public policy development

Basic Theme

- Assessment and early intervention
- prevention + promotion + education
- chronic care at the community level
- family / community support
- Need an infrastructure to support
  - collaboration
  - integration
  - public policy
  - cooperation

Assumptions

- Services in Communities will be:
  - outreach (brought in)
  - community based
- That an infrastructure which supports:
  - collaboration
  - cooperation
  - integration
  - cooperation

  is essential to maintain and support core services. We cannot have services without the support of an infrastructure.

Issues

- What does family care. evidence-based and core diagnostic services mean?
- How does this approach of integrated services fit into the existing family- based physician?
- Whose evidence to we take?
- The "as is" list is not comprehensive

Service	Community	Cluster	Province
Neurosurgery			X
Neonatal			X
Hematology			X
Specialized Geriatric Screening			X
Cardiac Surgery			X
Plastic Surgery - Burns			X
Drug Trials - with outreach			X
Specialized Laboratories			X
Pathology		X	X
Specialized Psychiatry		X	X
Pediatrics		X	X
Obstetrics		X	X
Ophthalmology		X	X
Thoracic/Vascular		X	X
Diagnostic Imaging		X	X
Geriatrics		X	X
Infectious Diseases		X	X
Dental Surgery		X	X
Specialized Mental Health		X	X
Psychiatric Rehabilitation		X	X
In patient Beds		X	X
General Surgery		X	X
Plastic Surgery		X	
Neurology		X	
Gynecology (not screening)		X	
Addiction/ Detox		X	
Cardiac Care		X	
ICU		X	
Urology		X	
Rheumatology		X	
Restorative Care		X	
Acute Care		X	
ENT		X	
Orthopedics		X	
Dermatology		X	
Nephrology		X	
Gastroenterology		X	
Repiratory		X	
Level II Emergency		X	
Speech/Language Pathology		X	

Service	Community	Cluster	Province
(This grouping includes outreach)			
General Surgery		X	X
Dialysis		X	X
Oncology		X	X
Laboratory		X	X
Rehabilitation Epidemiology		X	X
Assessment & Diagnosis		X	X
Screening of various types		X	X
Equipment Loan		X	X
Research		X	X
Specialized training (e.g. autism, supported employment, life skills, literacy)		X	X
Professional Education		X	X
Clinical Pathways		X	X
Cardiac Rehabilitation	X	X	
Step-down Acute Care	X	X	
Physio/OT	X	X	
Long term Care	X	X	
Assertive Community Treatment (serious mentally ill)	X	X	

Assumptions

- Telehealth is available across the province
- Provincial standards for Emergency Medical Services (pre-facility) and emergency Management (facility) will be followed.
- Broad based policy developed and coordinated at the provincial level are in place to support services at all levels.

Recommendations

1. Standards be developed and Clinical pathways created to establish care between the community / Cluster of Communities / and Provincial levels and the human Resources be put on place to support the standards / pathways. (Follow the continuum of care) (Includes high risk, high care and high volume).

2. Provincial standards be established to address accessibility around the issues of distance, geography, wait times, cost, and mode of transportation.

3. A provincial health information plan be established ASAP that will include provincial standards, clinical practice guidelines and care pathways as components of outcomes measures.

Small Group Session
Marilyn Pothier

Set up and Ground Rules

Ground Rules
- Open mind
- Keep in mind future proposals
- If we know what is in the community — then what is needed nearby
- Then check-in — is it working to be generic
- ensure to "call us" on "hospital focus"

Brainstorming Rules
1. Everyone participates
2. All ideas are counted
3. No criticism or judgements
4. Quantity is important
5. Be creative, build on the ides of others
6. No discussion
7. Give ideas as short headlines that express a complete thought.

Discussion after Brainstorming
1. What did you like about what was said?
2. What are some suggested additions?
3. Constructive criticism / improvement ideas?
4. General principles / criteria?
5. Issues or questions?

Session on Core Services at the Community Level

Brainstormed Services at Community Level
- common denominator — group that provides input
- general practice — access to doctors
- consultation systems
- basic laboratory (specimen collection)
- Home Health Care — health care is not just institutional
- Drug dependency
- Community health care — public health
- On going palliative care (with training not received in institutions)
- Community health assessment
- Prevention and Public Health
- Health Promotion
- holistic approach
- Home Based Care
- Mental Health Wellness & Services

- Addiction Services
- Early Childhood Services
- Rehabilitation and Support Services
- Women's Health
- Emergency Services — Level I
- Transfer system to Level II or III
- Youth Health Centres
- Elderly health Centre
- Community Centres
- Continuum of care for elderly
- Palliative Care
- Continuing education
- Community Wellness Workers * Child Poverty
- Respite Care

Contacts. linkages. integration

Likes

- Community health centre as a service model
- Emphasis on youth / mental health/ elderly — provided as part of Community Health Centre — model can incorporate other services
- one stop shopping
- holistic approach
- health promotion
- focus on wellness. maybe least expensive
- demonstration of balance of "spectrum of care" lifespan
- health centre providing services "where they live"
- keeping people well but also support for chronic and acute problems that can be dealt with in communities
- aggregate at wellness and on follow up with home based care
- glad to see public health included as important
- nice to see areas not "easily counted" included. e.g. public health

Constructive Thoughts

- Need to look at other issues and how we include them e.g. housing, justice. Basic needs that impact on determinant of health.
- Need to have social structure in place to handle social issues and community supports are needed.
- "Healthy Community Model"
  - there are models to help
- partnerships: need to use effective models
- need to tap into more community resources — utilize what is already available — mobilize
- Government agencies need to be able to "cross lines" — is happening more at community level
- Capacity at community level to collaborate and integrate resources.

Issues/ Principles:

- CHB frustrated in looking at determinants of health — felt lacked ability to make changes in broad spectrum
- We are not doing anything about "risk factors' we need to.
- Accountability mechanisms need to be put in place
- Haven't seen examples of true collaboration
- need to look at "evidence-based" — needed at community level decisions too.
- Community needs "resource of facilitating" activities and resourcing. Maybe provided by CHB
- Evidence is conflicting
- Ned to "results plan" and use benchmarking
- Need to consider relevance of research and set "goals" and outcomes. We have evidence but not policies/practice to reduce risk factors.
- Room for "community" in increased emphasis on reducing risk factors.
- Don't ignore other groups and agencies that are working on other determinants of health
- Need to be able to record data and use it in a "management" way.
- Need to identify that there are "quality and level" of service issues. Especially with acute care.
    - What can you provide
    - Critical mass - quality of care
- Community "access" f/s community delivery
- Question: Who has responsibility for delivery? Defines what is core at what level.
- Interlocking cascade of responsibility — leads to integration. Can't separate levels
- Need to revisit as things change
- All levels contribute to continuum of "care" for each individual — one size won't fit all.
- CHBs may not be aware of "what" is out there. Need to work together and learn from each other.
- Need to ensure supports are in place within communities.

Accessibility/Links

- Lab Services vs. (e.g. blood collection)
- distinguish between is done in "cluster" vs community: one component at community level — one at cluster level and one provincial; integration horizontally and vertically is needed — cannot delineate or isolate — partnerships
- Diagnostic services may be defined by "how complicated the service is", how cost effective, quality
- What we want in community needs to be based on "need" and what is reasonable. Now have links to experts so should be able to respond to more locally — Will change dynamics of interaction.
- Knowledge - services - can be available centrally or with an expert (can be located anywhere?), it can be transferred to those in community to deliver the care (e.g. Telehealth)
- Need to look at interregional relationships

Principles

- **Available Services**: means that a service is delivered at the level it is accessed.

- **Accountability**: Everyone is accountable to demonstrate cooperation through shared responsibility and flexibility.
  - needs clear roles and responsibilities and also vertical and horizontal links
  - responsible for delivery and meeting or outcomes?
  - maybe in partnership with another level: cluster, community, provincial.
- **Accessibility**: May not be delivered at the level it needs to be accessed. Closest to the person but is with support.
- This process should not be used as a rationale to "**cut**" or change without proven reason to change
  - reasons to be related to health goals and evidence based decision making
- We need to look at how we can better use what we have now.
- There need to be incentives to be "cost effective".
- Appropriate (accepted standards, guidelines, outcomes): the appropriate intervention for the right target group, in the right place.
- Anything that is medically necessary is provided to those who need it with no "additional" cost. These should be within the hospital and within the community (as interpreted by the province).
- Services must ensure that the following are considered:
  - safety issues
  - economic issues
  - competency issues
  - timelines issues
  - quality issues
  - critical mass

  These are interrelated.
- Information and data base is critical element to deliver integrated services — with good access — beyond health.
- Maybe integrate systems that already exist
- Need to **make the decision** about which one and implement it.
  - Assumed that critical mass and Human Resource issues would be part of decision making.
- If it should be available we need to commit to having resource available.
- Need to define chain of responsibility and accountability.

Uniquenesses
- System integration is as important as the particular services offered at each level
- Service needs and expectations

Assumptions
1. Start with models and principles
2. Lead to Services
   - prevention] links and partners betw/ all levels] resource inventory
   - protection] emergency responsibilities] assessment
   - primary care] family services, early
   - palliative care] childhood, Mental Health

- long term care] longer term
- respite
- public health

3. Leads to mechanisms for delivery — service model
4. Outcomes and evaluation.
   This cycles back to impact on all previous pieces.
5. Things at community — are automatically part of the cluster level and provincial level in publicly funded health services
6. Ill services are accessible and affordable
7. "Clusters" = regional and community hospital and services associated within catchment area.

Clusters Brainstorming

- Acute Care
    - general surgery
    - medicine
    - obstetrics / gynecology
    - level? of emergency services
    - lab services
    - radiology (diagnostic imaging)
    - physiotherapy / occupational therapy (rehabilitation services)
    - mental health services
- home care services
- nutrition and dietary
- palliative care
- anesthesia
- long term care
- addiction services
- environmental services (e.g. water testing)
- geriatrics
- restorative care (level 2)
- dentistry
- pediatrics
- orthopedics
- pathology
- public health (nursing, education, promotion, prevention, linkage)
- subspecialties
  - ophthalmology
  -
- access to recreational opportunities
- support for family care givers
- family counseling / crisis services / wellness
- public governance and decision making
- infrastructure for "integration - collaboration: working together of government, NGOs and

agencies, community groups & volunteers (within and without? CHBs can help), and provincial service providers

- funding process for health promoting community groups
- support for accessing services
- disaster readiness
- interdisciplinary continuing education
- provincial legislation should support healthy public policy
- complementary medicine
- information system
  - clearing house
  - varied to meet needs (e.g. literacy)
  - human involvement
- research opportunities (outcome measurement - funding 7 infrastructure)
- Ways for clusters of communities to initiate community development
- continued support for CHBs to help support community initiatives
- access to "assistive technology" and Mobility aids
- health promotion services (with different players engaged, not necessarily public health)
- social justice
  - recognition that this is not the responsibility of "one" department
- continuing education
- incentives to collaborate at cluster level
- employment issues?
- school based health practices?
- environment
- disaster readiness
- fire safety services (quick response in emergency)
- screening services (e.g. mammography)
- policing and shelter
- speech and deafness
- community pediatrics

Brainstorming for Provincial Services

- infrastructure for working together
  - within province
  - between provinces
- funding process and $$$$ available for health promoting groups and a commitment to shift from "illness model" to health education and promotion: **BALANCE** and **SUSTAINABILITY**
- recognition of transition — fear this needs $$$ and time
- funding for transition but decreased $ available — need rational decision making around reallocation and accountability to show shift of funding
- information and measurement activities — report cards, provincial comparisons — within and without
- structures to allow public involvement in provincial decision making and legislation

decisions

- cardiac services
- pediatric services
- mental health
- surgical subspecialties
- medical subspecialties
- addiction services
- obstetrical - high risk
- intensive care
- oncology
- diagnostic (Lab, Diagnostic Imaging)
- support for accessing provincial services
- transplantation services
- rehabilitation services
- emergency services (level 3)
- research
- education of health providers — University preparation courses
- information to public on health promotion and other health issues
- policy development
- quality assurance
- standardization
- environmental protection
- agency integration

Small Group Session
Naomi Mensink

Health Goals with Stories

- added to help understand the health goals and relate them to outcomes

- Healthy Environment

Story of the family in the Valley sprayed with pesticides, and no charges could be laid because there was no legislation to support such a charge. Later on the man doing the spraying could be charged with killing fish when he sprayed a stream.

- Health Promotion

Awareness of ways to stay healthy. New guidelines say that every person should have 60 minutes of moderate accumulated exercise. This helps with such things as lowering blood pressure, reducing effects of stress.

- Healthy Living

Building community gardens so that persons who have no space to garden can work the land. There is a chef who works with a grocery store in one community and teaches parents & tots groups easy, healthy meals and snacks. Schools are starting to develop breakfast programs.

- Management

Some school facilities are being used partially as community centres where various groups can use them during hours when school is not in. Some communities have adopt a grandparent for children, to benefit both children and elderly in the community.

- Participation

"Let's have a party!" Holding kitchen parties focusing on specific topics or issues related to health. Involve various groups such as self-help groups in health support — both formal and informal organizations.

- Social Justice

Support motivation to achieve health. One school has a "Snuggle up and read" program to encourage and promote literacy. Suggestion: do a pilot project where the target audience participates in the development of a brochure and promotional materials for a health promotion project.

Assumptions

- We need to challenge the assumption that the services we have currently are core.
- Smaller centres may provide services more efficiently and effectively than large centres if the volume is there.
- Collaboration, partnering, sharing makes improvement possible. Also makes accountability more difficult
- We often see utilitarianism operating: the greatest good for the greatest number of people. We need to make sure we look at sub-groups of the population (e.g. the Mennonite people around Truro) and make sure that sufficient attention is paid to the health of smaller groups that may be missed.
- Provide high tech/high cost care for people with special needs or who can't afford it.
- There must be equitable access for everyone
- Services must be acceptable to the people in the community(ies).
- Provide services close to home
- The individual / community / cluster of communities all have to have a sense of ownership. They need to be involved in identifying their own core services
- Look at all of this from the consumer's point of view
- Our talk about core services needs to focus on "people" — we need to talk about people
- Promote goals and outcomes by working together
- Let the media know what we've done and who was involved
- Focus on evolution, not reform
- Not to dismantle the good things we already have
- As we change, keep in mind organic integrity: if we take something away or add something, how will it affect the organization or community — what else will be impacted? — Impact analysis.
- Sharing of information to make successful coordination
- make coordination work from multiple entry points
- lifelong process designed around the whole person
- each level has its own accountability for aspects of programs

- Groups of clusters can share cluster based services
- population-based subspecialties

Community based core services

- Primary mental health for all ages (Different services needed in different kinds of communities)
- Care for the mentally handicapped
- health promotion
- health education
- illness and injury prevention (safe communities)
- care for seniors
- family medicine (access to primary care through service teams, not just physician) — includes medical and dental care — a basket of goodies based on community needs — community based
- nutritional counseling
- accurate information to mange own health
- support to access services away from home
- emergency care: first responders, ambulance, transfer, family doctor.
- dentistry
- schools
- libraries
- fire stations
- sidewalks
- physio
- children's mental health
- palliative care
- public health
- pharmacy & drugs
- speech/language services
- alternative medicines (Mi'maq, oriental, traditional)
- satellite clinics (for medical specialties and screening programs)
- recreation
- support and valuing for volunteer efforts
- children's health (including coordination0
- women's and men's health
- restorative care
- basic lab services

Cluster of Communities and Provincial Services

* CC= Cluster of Communities, P= Provincial

Services	Where Delivered	Accountability
Emergency:		P
• infrastructure,	P	
• coordination	CC, P	
• medical care, including trauma	CC	
Palliative Care (team)	CC	
Prosthetics / Orthotics	CC	
Child health		P
• policy coordination	P	
• public health, education, environment	CC	
Interagency Coordination and Cooperation (including information)	C, CC, P	P
Mental Health	CC, P	
Residential services for mentally handicapped	CC	
Acute care & specialty medical care		
• Oncology & Cancer Care	C, CC, P	P, CC
• Cardiology (including supspecialties and lifestyle counseling)	C, CC, P P	
• Cardiac surgery	CC, P	
• Nephrology (including dialysis)	CC, P	
• Ophthalmology (including subspecialties	P	
• Hematology	CC, P	
• Respirology	CC, P	
• Gastroenterology	CC, P	
• Rheumatology	CC, P	
• Urology	CC, P	
• Pediatrics (including subspecialties)	CC, P	
• Orthopedics	CC, P	
• Anesthesia	C (?), CC, P	P
• General surgery	CC, P	
• Pain management (as a medical specialty)	CC, P	
• Dermatology	P	
• Immunology	CC, P	
• Otolaryngology	CC, P	P
• Infectious diseases	CC, P	
• gynecology	CC, P	
• physiatry	CC, P	
• geriatrics		
• pathology		

Services	**Where Delivered**	**Accountability**
Acute Care and Specialty Medical Care • Neurosurgery • Thoracic Surgery • Transplantation of major organ • Vascular surgery • Oral surgery • Obstetrics	 P CC P CC CC, P CC	
Pharmacy	C	
Optometry	C	
Pathology	CC, P	CC, P
Care for mentally handicapped	CC	P
Policy and standards development	C, CC, P	

** This table does not list those standards and services delivered exclusively at the community level.

Principles

- for young children (mental health, etc.) as many services as possible close to where they live
- Avoid or coordinate for individual/community needs tertiary referral for primary needs
- Avoid duplication of services, including recognizing local assessments (create a seamless system)
- Check the definition of community with the public
- We need standards for access:
  - referral time and process
  - travel time
- there are really two levels of core:
  - all communities
  - some communities based on need
- Pay attention to barriers to access: language, culture, others
- Need clear accountability for emergency services

Summary Table of Core Health Services
Identified by Advisory Committee members

Service	Community	Cluster of Communities	Province
Community Health Assessment	5	1	1
Consultation systems	1		
Health & Community Services Teams (Primary care) • physicians • nurses • nurse practitioners • social workers • physiotherapists • occupational therapists • midwives (1) • community health worker (1)	11		1
Physicians (GPs or Family Physicians) • pre-natal and post-natal care • pediatric care • general medicine	6	3	2
Health Promotion (includes partnerships with Education and Recreation) • infrastructure creation and maintenance • pre-natal • post-natal • infant stimulation • breast feeding support • hearing & speech/language • parenting programs • sexual and reproductive health • nutrition counseling • substance misuse/abuse • family planning • mental health • suicide prevention • chronic disease education • lifestyle, parenting, coping • healthy heart / healthy lifestyle	14	4	3

Prevention and Public Health Services, including Health Protection (includes partnerships with Justice, Education, Housing, etc) • communicable disease prevention • education and prevention of non-communicable diseases • safety	11	4	4
Specialty services on rotation to regional hospitals			3
Rehabilitation, Developmental, and Support	5	3	3
Care Coordination – including technology for	4		1
Palliative Care	11	4	1
Home Based Care	12	4 (single entry)	2
Residential Care / Long Term Care • supportive living environments	6	2 (single entry)	2
Continuing Education for health service deliverers	1	1	2
Information system based on capacity building		1	2
Coordinated chronic disease care		1	
Mental Health Services (includes Education) - at community level: • assessment • self help • early intervention • forensic services (provincial only)	8	9	6 (specialty)
Addiction Services / Substance Misuse	7	6 (if not in community - 1)	1
Diagnostic Services (Lab & X-ray, etc)	9	7	3
Emergency Services • first responders • transport to appropriate care centre • trauma centre	10	6	4
Children's specialty services (early childhood services) • child poverty programs	2		2

Policy and standards development for • for an inclusive health care system • health promotion education • health protection • prevention and community health services • treatment, emergency & diagnostic services • developmental & rehabilitation support services • information management (1)		1	10
Research			1
Group to provide input and local decision-making	1		
Respond to public expectations and needs: • to increaemphasiss on prevention and early intervention • to meet the needs of vulnerable populations • to improve communications and tear down silos • to develop stronger partnerships • to be more accountable			1
Environmental health (includes environmental services such as water testing)		2	
Care Coordination (Case management) • technology for	1	1	2
Dentistry	4	2	
School health	2		
Youth health centres	4		
Elderly health centres - includes continuum of care for elderly)	3		
Community Development	1		
Adult Day Schools	1		
Rehabilitation • follow up after hospitalization	1	1	
Recreation	1	1	
Pharmacy / Drug Store	1		
Healthy Community Plan	2		
Cancer Care	1	1	1
Geriatric services	2		
Spiritual care	2	1	

Pharmacare			1
Poison Control			1
Family Services		1	
Disaster Readiness		1	
Complementary Medicine / alternative medicines		1	
Policing & Fire Services		1	

Acute and Chronic Care
• anesthesia
• burn management
• cardiac surgery
• cardiology (including subspecialities and lifestyle counseling
• cardiovascular surgery
• dermatology
• diagnostic radiology
• endocrinology
• family medicine
• gastroenterology
• general surgery
• geriatrics
  ▸ day care
  ▸ psychogeriatrics
• general medicine
• gynecology – general
• gynecology – oncology
• hematology
• immunology
• infectious diseases
• nephrology
• neurology
• neurosurgery
• obstetrics – high risk
• obstetrics – routine pre- and post-natal
• occupational therapy
• oncology – medical
• oncology – radiation
• ophthalmology
• oral & maxillofacial
• organ transplantation surgery
• organ transplantation follow-up
• orthopedic surgery
• otolaryngology
• pain management
• pediatrics – general & subspecialties
• pediatric oncology
• physiotherapy
• radiology
• reconstructive & plastic
• respirology
• rheumatology
• thoracic surgery
• urology
• vascular surgery
• women's health and wellness
  ▸ obstetrics and gynecology			

Principles

- Lab & X-ray services should be within 30 minutes drive from any community
- involve other community groups (garden clubs, etc)
- coordinated communication is important at the community level
- CHBs revisit Health Plans every three years
- central outpatient services for specialties should arrange appointment times taking travel time into consideration and coordinating appointments from communities so that car pooling is efficient
- at the regional level have well-persons information session taht rotate throughout the cluster of communities
- Support the services outlined in the Department of Health 1996 document (2 comments)
- make sure community services are community driven with elected Boards of Directors working with other stakeholders
- regional services should not revolve around the regional hospital
- holistic approach
- public governance and decision making
- use community centre as base for services

Provincial
Health Council

Core Services Public Consultation

Advisory Committee

Participant Evaluation

November 25 & 26, 1999

Suite 301
1888 Brunswick Street
Halifax, NS
B3J 3P7

Participant Evaluation

Provincial Health Council
Core Services Advisory

November 25 & 26, '99

Please indicate the extent to which you agree or disagree with the following statements using the scale below.

1	2	3	4	5
Strongly Disagree	*Disagree*	*Not Sure*	*Agree*	*Strongly Agree*

The Session Itself	1	2	3	4	5
1. The session objectives were worthwhile.	☐	☐	☐	☐	☐
2. All things considered, the timing was good for this session.	☐	☐	☐	☐	☐
3. Small group activity was effective .	☐	☐	☐	☐	☐
4. Large group activity was effective.	☐	☐	☐	☐	☐
5. The visual aids were effective (overheads, handouts, flipcharts, etc.)	☐	☐	☐	☐	☐
6. The session moved along at a good pace.	☐	☐	☐	☐	☐
7. Overall, the session was effective.	☐	☐	☐	☐	☐

The Facilitation	1	2	3	4	5
8. The facilitators communicated clearly.	☐	☐	☐	☐	☐
9. The facilitators welcomed comments and questions.	☐	☐	☐	☐	☐
10. I felt able to participate as much as I wanted to.	☐	☐	☐	☐	☐
11. Overall, the facilitation was effective.	☐	☐	☐	☐	☐

The Outcome	1	2	3	4	5
12. The session met its objectives.	☐	☐	☐	☐	☐
13. The session furthered our progress.	☐	☐	☐	☐	☐
14. The session was worthwhile.	☐	☐	☐	☐	☐

Please be sure to complete the other side

Core Services Advisory
November 25 & 26, 1999

Please complete the 5 spaces below, in relation to your experience with the session.

1. I came into this session expecting .....

2. What I've actually experienced was .....

3. In my opinion, here's what went well with the session.....

4. The session could have been improved by.....

5. What do you think should happen next ?

Please be sure to complete the other side of this sheet. Thanks.

PARTICIPANT EVALUATION

The following results were obtained from 25 responses to the participant evaluation at the November 25 and 26 meeting of the Advisory Committee.

1 - Strongly Disagree 2 - Disagree 3 - Not Sure 4 - Agree 5 - Strongly Agree

Question	Answer					
The Session Itself	1	2	3	4	5	None
1. The session objectives were worthwhile	-	1	4	12	5	3
2. All things considered, the timing was good for this session.	2	1	3	13	4	2
3. Small group activity was effective.	1	2	2	14	6	-
4. Large group activity was effective.	1	-	5	18	1	-
5. The visual aids were effective	-	2	4	15	3	1
6. The session moved along at a good pace.	1	2	2	16	3	1
7. Overall, the session was effective.	-	2	9	12	2	-
The Facilitation						
8. The facilitators communicated clearly.	2	-	1	13	11	-
9. The facilitators welcomed comments and questions.	2	-	3	9	13	-
10. I felt able to participate as much as I wanted to.	1	1	1	11	13	-
11. Overall, the facilitation was effective.	3	-	2	9	14	-
The Outcome						
12. The session met its objectives.	1	4	9	8	1	2
13. The session furthered our progress.	-	2	9	10	3	1
14. The session was worthwhile.	-	1	6	11	6	1

Comments

Three respondents gave two answers in the facilitators' section - one for W. Marsh (who scored 5), and for another facilitator (who scored 1-2).

"(One NRHB) She tried - but really wasn't clear on the tasks - easily diverted to participant role - etc."

Question #2 - "Too much ed. talk"

Question #3 - "Some facilitators not good."

Question #5 - "Could have been stronger."
"Needed more on health states."

Question #7 - "What happens next is important."

1. I came into this session expecting...

To clarify definition
To clarify roles
To share ideas and concerns
Help in selling consultation to community.

To define more exactly - the core services for the three levels.

Confusion, disagreement and self-interest.

To clearly define core services/programs at the three levels, i.e., community, cluster, provincial

Frustration
People just going through the process
A narrow discussion focusing on health services and not the broader health outcomes

To feel like I came expecting to look at ways which we might make connections (well done!) among various agencies, as well as look at a list of core services. I think we've done this on an information level and perhaps need to look at it more.

To discuss ways and means and then shelve the information.

To communicate the need for more effective health promotion and healthy public policy.

Far less support for health promotion and community development principles
Lots of talk about "beds"
Hoping for a shift in thinking

Absolute definitions of boundaries at all levels of services/availabilities.

My expectations were that would work on the three levels of core and prioritize their function. What we did do was to examine needs at each level without reference to the proposed structure. This was good.

A challenging exercise with diverse opinion and difficulties in speaking the same language, e.g., nomenclature problems.

To assist PHC with this mandate - input to core services, primary, secondary and tertiary.
That people - CHB's, etc., were beyond wanting to debate definitions of health and commun.

Discussion about key components in achieving core services.

To have core services identified.

More resistance to a health promotion/community development services/inclusion.

A list of just "services" at the three levels.

To have a clear sense of identified core health services.
To identify quickly core services and who is responsible (i.e., c. cc and p).
Then by next day work on identifying what is doable and develop questions from results of above for public at public meetings at level "they" (community) could understand.

I wasn't sure what to expect - this is not the first time these issues have been discussed.

I came with mixed feelings. I didn't expect the completion of the core services.

That people/prov. Were beyond basic understandings of definitions - community, health, etc...surprising to me how little we've actually moved in this understanding over several years.

Some meaningful input at a community level.

Clarity

2. What I've actually experienced was...

Roles are more clearly defined. Not sure if I can sell the consultation process to community., because we had to much trouble with definition.

A more broad approach and development of assumptions and principles for the PHC so they can go ahead.

Agreement. shared interest. a desire to see/support a system and its three key elements and partners.

Many diverse opinions trying to improve the quality of life in the "health" of Nova Scotia. People are definitely committed to this aspect!

More interested and committed people.

Wonderful! I have learned much and had the opportunity to provide a small voice with regard to the importance of working with other services such as education. recreation, justice. etc.

An awakening. Everyone (including the Deputy Minister) appeared to want evidence of change, movability and progression.

Looking at long lists of medical services
Not spending any time on prevention measures...

Support for health promotion and c. development princ.
A surprise that the focus was not beds
People's willingness to try to understand.

Lots of frustrations.

I experienced a real mind search and expansion of previous ideas and all ideas were noted.

As above (a challenging exercise with diverse opinions and difficulties in speaking the same language, e.g., nomenclature problems) - however a positive, open dialogue generating many important thoughts and identifying strategic issues

A common understanding of larger systems - intersectoral/government issues.

Confusion about terms/concepts such as cluster, community, core services. The perception that it's a token gesture. Government hidden agenda by some participants.

I'm not sure we identified core services - rather we talked about what health was to us.

We identified that lots is being done at the community level but more is needed. There are disagreements re: how to do this but not about it being done. I'm concerned that we didn't really do what we were asked to do and that may have a negative impact.

Acceptance and valuing of "community" input
Difference in level of understanding between CHB people. in particular, and others re: significance of early Fri. discussion (implications for community consultation?)
Support from all areas on integration of services beginning at the community level which makes sense but not what I expected to be discussed.

A sense of deja vu...we've been around the health block too many times with same discussions that don't lead to concrete results.

Quite frustrating
Spent most of time (80%) in each group making lists which weren't shared with lg group but 20% on what was presented.

A willingness to try this once more with the expectation that something will happen.

Frustration. Not because of the intent of the organizers - they are all terrific. Frustration with the lack of definition of the task. mixed messages. i.e.. the outcome (Provincial Health Council vs DOH). Fear that this will not mean anything, expect the government to say "the government consulted."

Reasonable and expected periods of frustration and confusion: good opportunity to hear and listen to others. A willingness to participate with an open mind; and some challenging of the goals and obj. as being reasonable.

An agenda put forward by the province - hopeful that the community would agree.

Confusion
Frustration
Chasing our tails

3. In my opinion, here's what went well with the session...

Facilitators great - both at big group and small groups. B. Anderson/M. Pothier.

The varied options which were valued. The richness of the human resources in the room. I learned a great deal.

The task was a source of a lack of clarity several times.

Most people listened to the views of others - sought consensus - pace, focus, facilitators and participants from beyond "the system" as providers might perceive.

The opportunity for individuals to participate at many levels. Comments were accepted and appreciated.

We discussed health outcomes and the need to eventually move the services into outcomes.

We did accomplish the goals of the session. It also stimulated a lot of discussion and we feel there are goals to set for the future.

The flexibility of a myriad group to veer from the aims and objective that were thought to be the goal of the conference.

Met a lot of new people who are very committed.

Thursday's discussion at the community level.
Friday a.m. early discussion that started to get at outcomes/results.

Interaction was very good though (I felt) that with all of the high level of education and expertise of the government employees, I was lost in the stampede of ideas and points brought up.

I think that well expanded our thoughts beyond the mere clinical level to an all-inclusive approach to better health.

Facilitator was excellent
Great exchange of ideas and identification of much common ground.

Respect for participants.
Equal opportunity for input; lists of core services brain stormed but no comprehensive review/consensus.

Small group discussions.

People talked with each other helping each other understand what they mean by health and how health services can be provided.
Wonderful understanding and appreciation of each other.

Small discussion groups
Organizational details.
Discussion from the whole diverse participants.

Good opportunity for questions. discussion.

Meeting people from all over Nova Scotia and not just in health fields.

Facilitation was good in groups I attended.

Good brain storming
People respected and listened to each other
Identification of (breakthrough) need for standards. practice guidelines. pathways to shape outcome measures and information system req.

Presentation
Discussion periods.

Wayne's skills in: listening, summarizing. moving forward. adapting. reflecting (with humour. tact!).

4. The session could have been improved by...

This was great but we need to keep the process going - this will be a leading breaking document which will need constant updates.
Good luck.

· Case study examples to illustrate major themes - linkages, outcomes, decision-making, core and resource allocation. etc.. etc.. etc.

Opening up the discussions on the second day was confusing to many people. I think I would have had that discussion prior to closure!

Better pre-planning with health status indicating budget.
A presentation from the viewpoint of what is the current health status, what works to create health.

I thought it was a very well planned and facilitated session from an educational background and think it is very important to keep these agencies working together again!

An additional day. What we thought would be the heart of the discussion wasn't and we were astute enough to realize this.

Focusing on outcomes
Evaluating "programs" as strategies to achieve outcomes
More info about Nova Scotians' health status.

Changing the direction after Friday morning's discussion.
Involving others from other sectors - not for profit, other departments
Establishing outcomes up front.

More definitive guidelines.

I'm not exactly sure it could have been better except for time restraint.

More time to fucus on actual core services as that was the key deliverable for the two days.

Looking at health goals vis a vis targets and outcomes.

Having the Deputy Minister's presentation after group discussions.

Clarifying up front the objectives/goals for the workshop. The amount of latitude we had was not made clear and while what we did was good it may be for naught. How useful will this work be to the government - as they look at what they must do over the next few years.

Clearer context, philosophical/values/structural framework to attach "core services" to knowing impact of financial review.

Including how the integrated services can be achieved.

Focusing more on specific examples to illustrate generalities.

Keeping to a "time" schedule
Clearer directions
All cell phones should be turned "off" - please
Terms may have been difficult for "non-health" people to understand - sug - no acronyms. etc.

Having clearer definitions to start with and a framework around which the work could be developed.

More clarity around the expected outcome. Definitions.

Avoiding references to "regional level."
Eliminating visual references to "community, clusters and province" - pokes chips. etc.: better group facilitation - one person was ineffective and off the mark.

Listening to communities. Some attempt at addressing what the expectation was, rather than go through hoops.

More Waynes or facilitators with his skills for our small group sessions (facilitator did not listen and interrupted and over-ruled, even in brain storming). I only experienced one other facilitator over two days.

5. What do you think should happen next?

Continue this process with more stakeholders at the table - we need a framework outcome expectations - we need to meet - to continue the work.

Get the stuff back to us
Get group together, with expansion of membership to articulate outcomes/results
Get commitment from government to support this approach to it
Host public discussions with food, where people are to gain public input

For the council to develop a position paper on how the province should shift to a prevention model that is balanced with the medical model.

Come together after draft done if possible.

Public awareness/education piece to "prepare" general public to take part in consultation, e.g., questions/answers/examples around definitions, values, process and health goals, principles
Bringing group together to review common themes, education piece in workbook, etc.

This group should reconvene after community consultations.
Tremendous effort needs to go into public consultations. It needs to be as much an education session, re: health goals, determinants, etc.
Need to involve epidemiologist, e.g., Dr. David MacLean
Relevant data - provincial health surveys, David MacLean
- Heart Health Nova Scotia (494-1960), Jane Farquarson

Another session discussing integration of services with all the players.

Another two days now that we have established (we believe) the criteria that will mean at last a successful venture.

Group needs to look at summary document and provide feedback. Ministers and deputy ministers need to support the concepts, public consultations need to be held and the planning for them must reflect some of the concerns, advice given by the group.

Group needs to get back together to (a) discuss the document, (b) review what happened with community consultation. People will come to a public meeting - if they feel threatened, expect to gain or lose something!

More and a continuing involvement by the groups which attended.

I think we need to come back to re-examine what was done after it is blended and, after public consultation, visit the results again for final consideration.

1. More of this brainstorming as the process goes on.
2. Set up "ombudsman" to interact between government agencies to aid in reduction of costs and facilitate the health care/wellness system.

Provincial Health Council needs to send a clear message to government that this process will not be a rubber stamp for cost-cutting re-structuring that has already been decided by cabinet.

Work on health population outcomes.
Political - intersectoral government commitment.
Use existing data.

Follow through on the suggestions of Fred French and Linda Hamilton and others from first part of second day.
I'm okay to meet again, if purpose is clear.

The DOH needs to clearly articulate its intention and lead the process. Use the Provincial Health Council to do its real job. You are a great group.

Strategic issues should be related to government
PHC and government ensuring this consultation process is honest and meaningful in view of budget realities coming in April. 2000.

Clarify CORE services list so that we are clear about service scope, content - get past being too general for core to be meaningful and useful in future resource allocation.

I feel there should be a follow-up session. I feel that it provides a checkpoint as well as a summative opportunity for this work! I believe also that we need to look at outcomes based plan which includes all agencies to promote the health of all Nova Scotians!!! Department of Education works from an outcomes based model. Atlantic Provinces Education Foundation documents.

(Give) incorporate assumptions. Recommendation of small groups to the government. Listen to what was said. Action be taken. Follow-up session - of this group.

Provincial M.H. Review Team needs to be included.
Broader group should be brought together with the available population health/epidemiological data to shape expected outcomes for the broad health goals; the work of the Prov. Perf. Indicators and Health Info. Systems working Groups should be integrated at that time. Deputy Minister should be at the table and public information/feedback venues operationalised thereafter. PHC follow-up on recommendations and Public education about integ. health system.

Clarify function of health council - i.e., advisory to government - not decision-makers (monitors of system).
Commitment from government generally with respect to doing something and responding to

consultation process.

Come back to the group, after the work-up. Provide some awareness to the expectations.

Meet in April for proper closure - i.e., what has occurred and where do we go next. I would like to say you did an excellent job - and thank you for providing me with an opportunity to participate - I wish you all the best in your future aspirations.

Report circulated to Advisory Committee for feedback before final (maybe a meeting of a small group representing this group).
PHC to take on an advisory/monitoring role with regard to core services.

AGENDA

Advisory Committee
to the
Provincial Health Council
Westin Harbourfront B
June 5, 2000

By the end of the session we will have .....

√ Reached a common understanding of the findings and conclusions from the public consultation.

√ Heard about progress toward the identification of Core Clinical Services.

√ Considered the implications of all consultation findings.

√ Provided input to a Provincial Health Council report and follow-through strategies.

Morning

1.0 Opening Remarks

1.1	Welcome	Council Chair
1.2	Core Clinical Services Update	R. Manuel, DoH Clinical Footprint Ctee
1.3	Précis of the Public Consultation	J. Dow & N. Mensink
1.4	Review of the Agenda & Approach for the Day	W. Marsh

2.0 Public Consultation

2.1	What stands out from the findings & preliminary conclusions? (a) The public's issues & strategies, priorities and recurring themes (b) Similarities & differences compared to this Advisory Committee's issues and recommendations in November	Small Groups
2.2	Potential implications of your responses in 2.1	Small Groups
2.3	Reporting back	Small Group Spokespersons
2.4	Facilitated Dialogue	Large group

Afternoon

3.0 Advice to Council : Contributing to a Balanced & Informed View

3.1	Identifying key issues & developing recommendations to the Council	Small groups
3.2	Reporting back	Small Group Spokespersons
3.3	Facilitated Dialogue	Large group

4.0 Sober Second Thought

Revisiting the day's work ..... progress and unresolved issues .... next steps.

SMALL GROUP INSTRUCTIONS
(Morning)

Tasks	Explanation	Time Budget
	GETTING ORGANIZED	
Introductions	Have each person at the table quickly introduce themselves by telling the others : • their name ; • the organizational affiliation that brings them here ; • the role that they play with that organization.	5 to 7 minutes
Pick a Facilitator/ Timekeeper from within the group	S/he will help the group by seeing that : 1. Each person gets a chance to contribute throughout this small group segment ; 2. The group uses its time wisely in completing the assigned task.	1 minute
Pick a Recorder/ Reporter	S/he will: 1. Write the group's main train of thought on the flipchart provided ; 2. Provide a summary report of the group's ideas back to the larger group.	1 minute
	THE PUBLIC CONSULTATION	
Task # 1 Reactions	Have everyone in the group answer the question, "What stands out to you from the findings and preliminary conclusions that Health Council described in the pre-distributed material? Consider at least these 2 perspectives on the question : (a) The public's stated issues & strategies, priorities and recurring themes ; (b) How those findings were similar to or different from this Advisory Committee's issues and recommendations in November.	30 minutes

(more, over)

THE PUBLIC CONSULTATION
(cont'd)

Task # 2
Implications

Given what stood out to your group about to the findings (identified during Task #1), what are some of the potential implications ?

25 minutes

You might want to talk about ....

- what is implied about the *future health of Nova Scotians* ;
- issues raised concerning the future of the *health system* ; or
- *risks* that you foresee ...... and *opportunities*.

A good way to talk about implications would be to fill in the blanks in the following sentences ....

"If it's true that ______________ , then (someone or something) will have to ________ or else ______."

"Unless (someone or something) ______________ then it would appear that ______________ "

"If it's true that ____________ then we should be striking while the iron is hot, so that "

Task # 3
Prepare to rejoin the large group

Take a few minutes to make sure that you have consensus on what will be reported back to the large group.

5 minutes

SMALL GROUP INSTRUCTIONS

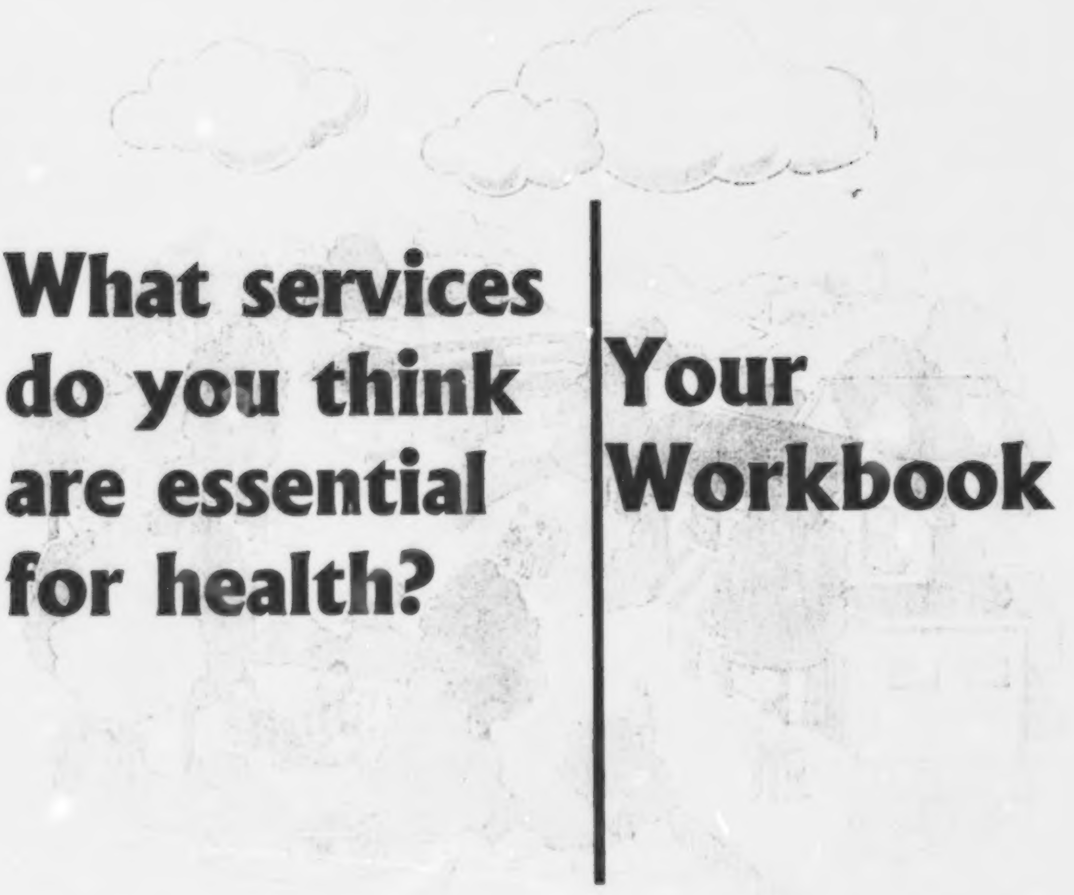
(Afternoon)

Tasks	Explanation	Time Budget
	GETTING ORGANIZED	
Introductions	As for the morning, if there are new people in the group.	5 to 7 minutes
Pick a new Facilitator / Timekeeper from within the group	Ask the person to the right of the one who acted as Facilitator/Timekeeper this morning.	1 minute
Pick a new Recorder, Reporter	Ask the person to the right of the one who acted as Recorder/Reporter this morning.	minute
	ADVICE TO COUNCIL	
Task # 1 Key Issues	1. Quickly brainstorm up to 10 areas on which you could see providing the Council advice as it prepares its report to Government.	5 minutes
	2. Reach consensus on 3 to 5 from the brainstormed list for which you will try to develop recommendations if the time permits. To narrow down the list, try to find the issues with the best combination of (a) potential impact *and* (b) feasibility ..... i.e. the likelihood that the Health Council can use public input to influence the Government's thinking and decisions.	5 minutes
Task # 2 Recommendations	Draft specific recommendations for each of the issues identified in Task #1. (If you've picked 5 issues, that works out to about 15 minutes each). Your recommendations will influence how the Council finalizes its report, including its own recommendations.	80 minutes
Task # 3 Prepare to rejoin the large group	Take a few minutes to make sure that you have consensus on what will be reported back to the large group.	5 minutes

Appendix 3
Workbooks

3.1 English
3.2 French

Provincial
Health Council



What services do you think are essential for health?

Your Workbook

Suite 301
1888 Brunswick Street
Halifax, NS
B3J 3P7

White pages – please complete

Green pages – optional

Provincial
Health Council

Dear Nova Scotian:

The Provincial Health Council has been asked by the Government of Nova Scotia to develop a list of health services that must be delivered to Nova Scotians.

The Council has agreed to deliver this list of services to the Ministry of Health by mid March 2000.

We are asking you, the citizens of Nova Scotia, to help us in this work on your behalf. We have developed this workbook to help us gather information from you so we can compile the list to include the health services you consider important to your health. Please take the time to fill out one of the workbooks and either bring it with you to one of the public meetings or use the self addressed, stamped envelop included with the booklet to return it to our office.

In addition to your opinions gathered from this book , the Council is carrying out several other activities to gather information. These include:

- using information from the Community Health Plans created by the Community Health Boards of Nova Scotia
- research into activities in other Canadian provinces
- research into activities in the United States and several European countries
- research into activities of the World Health Organisation
- creation of an Advisory Committee with representatives from the public; the health care system; the Departments of Community Services, Education, Justice, the Environment, Sport and Recreation; the professional organisations like the Medical Society of Nova Scotia and the Registered Nurses Association of Nova Scotia; organisations like Heart Health, Alzheimer's Association, Community Links; and individuals with a strong interest in the health of Nova Scotians. This Advisory Committee will provide advice to the Council about health services in Nova Scotia.
- seeking public opinion through face-to-face meetings in various communities across Nova Scotia
- seeking public opinion through the use of a 1-800 phone line
- seeking public opinion through use of a questionnaire on the Health Council Web site

You can see from this list of activities that we are using a variety of information collection tools to collect information on your behalf. All this information will be collected together to create a document for the Council to use to provide the Government of Nova Scotia with advice regarding the health status and needs of Nova Scotians and also to provide the Government with a list of the health services you, the citizens, consider to be important.

We would like to thank you for your participation in this project. The results of our efforts will be provided to the Government in March of 2000 and made public at the same time.

Sincerely,

Barbara Hart
Chair, Provincial Health Council

Tom Bird
Chair, Core Services Committee

The Provincial Health Council has been asked by the Government of Nova Scotia to hold province-wide public consultations to develop a list of core clinical services that must be provided at the community, regional and provincial levels. *(NS Government Platform Item)*

First, a bit about the Provincial Health Council

Mission Statement

The Provincial Health Council listens and responds to Nova Scotians.

We support the public's participation in health matters by providing you with information and opportunities.

We guide and monitor government decision making on all aspects of healthy public policy.

We promote the use of Nova Scotia's Health Goals as an essential tool to achieve health and well-being for Nova Scotians and your communities.

Formal Vision Statement of Council

"By the end of 1999,

We will have established effective reciprocal communications with Nova Scotians about health and the health system.

We will also develop a balanced and informed view of the health system that will enable us to provide timely advice and leadership to government and to Nova Scotians."

The Health Council Act outlines the Duties of Council as follows:
The duties of the Council are to advise the Governor in Council, through the Minister of Health, in the development of a comprehensive health policy, comprising health goals and objectives and in setting the overall direction of the health care system in the Province.

Manner of performing duties
In carrying out its duties, the Council shall
(a) invite community organizations, health care providers, consumers and individual members of the general public to provide advice on health issues under review by the Council through methods including public meetings, hearings and distribution of briefs and discussion papers;
(b) provide to the Governor in Council a balanced and informed view of the health care system;
(c) review particular issues referred to the Council by the Governor in Council, through the Minister of Health, and advise the Governor in Council on those issues;
(d) increase public awareness and knowledge of health issues, including population health status, the cost of the health care system and personal responsibility to improve health;
(e) enhance the awareness of Government of emerging health issues from the public viewpoint.

Introduction

Welcome and Thanks!

Welcome to your health services Workbook!

We, the Provincial Health Council, have been asked by the Government of Nova Scotia to develop a list of health services that must be delivered to Nova Scotians. In order to do this, we need your help.

We have consulted the Community Health Plans you have already prepared. We have done research on what other provinces and countries have done. We have already asked many of the providers of the system what they think should be provided, and now we are asking you, the citizens of Nova Scotia, what you think you need to become healthy and to stay healthy.

This workbook has been prepared to help you, whether you are an individual, a group, agency, organisation, government department, or community, provide us with information to develop a list of services that should be available at the community level, at a regional level, and at a provincial level to help Nova Scotians achieve and maintain healthy lives.

Your opinion is very important to the Council, and we are looking forward to receiving your ideas and suggestions. We appreciate the time and effort you are contributing to this process.

How To Use This Workbook

1. **Use this workbook** to record your answers to the questions about services.

All answers, long or short, are useful to us. Additional comments are welcome and if you need more space, please feel free to attach a separate piece of paper.

2. **Please fill out the evaluation form**. Your responses will assist us in further community consultation.

More Information

If you have questions about this workbook or the process we are undertaking, please call either **John Dow** or **Louann Scallion Morine** at the Provincial Health Council Office at 1-800-854-0815 or if you are in Halifax at 424-1639.

Nova Scotia's Health Goals

- ***Health Promotion: Promote and improve the health of all Nova Scotians.***

  While continuing to provide quality health care, we will shift our emphasis to the promotion of health and the prevention of illness, disability, and premature death.

- ***Healthy Environment: Make Nova Scotia a safe and healthy place to live.***

  To be healthy, we need clean air, water, and soil, as well as safe places to live, work, and play. We will restore, protect, and develop our environments to support health.

- ***Healthy Living: Support the efforts of individuals, families and communities to lead healthy lives.***

  We will support each other in our efforts to understand the factors that affect our health and take responsibility for those things we can control.

- ***Management: Ensure that the resources needed to support health are managed wisely and fairly.***

  Our taxes pay for the people, programs, equipment, and facilities that support health. These and other resources will be used in ways that are open, effective, efficient, and accountable.

- ***Participation: Involve Nova Scotians in decisions affecting health.***

  Opportunities and support must be provided for all of us to participate in making decisions about our health and he health care system. All decision makers are accountable to the public for their actions.

- ***Social Justice: Ensure that all Nova Scotians have the opportunity to achieve health.***

  Poverty, unemployment, racism, illiteracy, violence, rural isolation, and other issues make it more difficult for some people to be as healthy as others. The policies we put in place must address these factors that affect our health.

Things that Affect Your Health

- ***Income and Social Status***
  Greater income & higher social status generally equals better health.

- ***Social Support Networks***
  If you have the support of family and friends you are generally healthier.

- ***Education***
  Higher educational levels lead to better health.

- ***Employment and Working Conditions***
  The more control you have over working conditions and employment, the healthier you will be.

- ***Physical Environment***
  Exposure to harmful physical, chemical and biological agents can damage your health.

- ***Social Environment***
  Social support and isolation, emotional deprivation, stress, learned coping skills all have an impact on your health status.

- ***Biology and Genetic Endowment***
  Your family history of health and illness can affect your own health.

- ***Personal Health Practices and Coping Skills***
  The choices you make about things like smoking, sexual practices, health care practices and diet all affect your health status.

- ***Healthy Child Development***
  The best way to ensure that a group of people is healthy is to make sure that its children have a good start in life. A well nourished, educated and challenged childhood will lead to a healthy adult.

- ***Health Services Available***
  The health services available play a small part in your health status. The health service that most affects the health of a group of people is getting rid of childhood diseases.

- ***Gender***
  Women still live longer than men.

- ***Culture***
  Culture plays a large part in the way we relate to health, illness, the health care system, our lifestyle choices and many other areas of our life.

	Where do you think this service should be available?		
Service	**Community**	**District or Region**	**One place only in the province**
Health Promotion - Helping people to learn how to be as healthy and well as possible. Example: Children in school learning how to eat the right things to stay healthy. Parents getting together to learn how to prepare healthy meals and snacks cheaply. A nurse who checks the health of new babies and who helps mothers understand how to care for their babies.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Illness and Injury Prevention – Example: Providing flu shots to people who risk becoming very ill such as the elderly.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Health Protection - Things that protect us from illness or accidents. Examples: Meat inspections in grocery stores, education on communicable and non-communicable diseases, no-smoking areas in restaurants, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Home Based Care - Care you can get in your own home when you are sick or hurt. Example: A nurse who helps at home after you have had surgery.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Palliative Care - Help and support for people who are dying.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Residential Care (Long Term Care) - Homes for people who need extra support and care for daily living. Example: Nursing Homes.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Addiction and Substance Abuse Services - Programs and services that help people who have become alcoholic or who misuse drugs. Example: Alcoholics Anonymous.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Service	Where do you think this service should be available? Community	District or Region	One place only in the province
Developmental, Rehabilitation and Support - Helping people with physical handicaps or disabilities to do more or to live a full life. Examples: Help with learning to walk and talk again after a stroke or accident where someone's head is badly hurt.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Community Health Assessment - Example: A Community Health Board asks people in the community what they need to help them to be healthy, and checks information about how healthy people in the community are.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Community Acute and Chronic Care - Sickness and injury care that is in each community. Example: Doctors who see patients who are sick either with a short term illness or with an illness that lasts a long time.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Regional or District Acute and Chronic Care - Sickness or injury care that is shared by a group of communities in the same area. Example: A regional or district hospital with an emergency department.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Tertiary Acute Care - Sickness or injury care that is done only by specialists, where you have to be sent by a general or family doctor. Example: A heart surgeon in Halifax.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Services that address the things that affect health, other than health services (broad determinants of health)	**What examples from your community show how these affect your health?**
• Employment	Example:
• Education	Example:
• Income support	Example:
• Housing	Example:
• Social support networks	Example:
• Clean air and water	Example:
• Transportation	Example:
• Recreation	Example:
• Policing & fire services	Example:

What we believe about health for Nova Scotians

	How important is this belief to you?			
	Most Important	Quite Important	Somewhat Important	Not Important
1. The Health Goals for Nova Scotia tell us what total health is and how we can achieve it. We know that health is affected by a wide variety of things around us, not just health services (broad determinants of health).	☐	☐	☐	☐
2. We need to create a system that coordinates different government departments, public groups & societies, as well as businesses, to support health. Information needs to be shared between those service as it is needed. This system will make people's access to health services easier.	☐	☐	☐	☐
3. Services that help us improve and maintain good health must be available as close to home as possible, remembering that some services can only work well if there are enough people who need them.	☐	☐	☐	☐
4. Communities must be involved in decisions about services that affect their health.	☐	☐	☐	☐
5. Nova Scotians are becoming older, so we must organize services that affect health with that in mind.	☐	☐	☐	☐
6. Legislation, policy and standards need to be set by the Nova Scotia Government which support Nova Scotians in maintaining their own health.	☐	☐	☐	☐
7. We have already done a lot of good work in Nova Scotia about health. Let's use it.	☐	☐	☐	☐

Other Questions to Think About

Vision

- What vision do you have for health in Nova Scotia?

Priorities

- If you could have only three services that affect health in your community, what would they be? (That is, what are the three most important services for you?)

Health Promotion

- What information do you need to stay healthy? How do you get that information now? What further information do you need? How would you like to get this information in the future?

Illness and Injury Prevention

- How can we as Nova Scotians do a better job to prevent illness and injury?

Healthy Environment

- What do you think is the first thing we as Nova Scotians need to do, to help us have a healthy environment?

Healthy Living

- How do you think we can live more healthy lives?

Wise Management of Resources

- What ideas do you have about using our resources wisely to promote and support health for Nova Scotians?

Public Participation

- What would help you to become or remain involved in making decision about our health and the health system?

Social Justice

- What do you think is an important policy to have in place to ensure that all Nova Scotians have the chance to be as healthy as they can be?

Evaluation Form: Discussion Guide/Workbook and Consultation Process

	NO	SOMEWHAT	YES
1. Do you believe the discussion guide provided you with the background information you needed to address the questions in this workbook?	☐	☐	☐
2. Was the information in the discussion guide well organized?	☐	☐	☐
3. Were the instructions for using the discussion guide clear?	☐	☐	☐
4. Were the instructions for completing the workbook clear?	☐	☐	☐
5.a.) Have you attended a public meeting?	☐	☐	☐
b.) Do you plan to attend a public meeting?	☐	☐	☐
c.) If YES, was it or will it be: A community meeting sponsored by the Provincial Health Council	☐	☐	☐
OR A meeting sponsored by an agency/organization of which you are a member	☐	☐	☐
d.) If NO, were you aware that public meetings were being held?	☐	☐	☐

6. How did you obtain this copy of the discussion guide/workbook?

7. Do you have any additional comments about the discussion guide/workbook?

8. Do you have any additional comments about the Council's consultation process as a whole?

Background Information

You do not have to answer the following questions, but it would be helpful for future planning if we knew more about who is participating in the Council's consultation process. Kindly respond to the following questions:

9. Which community in Nova Scotia do you live?

10. Do you, or have you previously worked in the health care field?

NO ☐

YES ☐

11. If YES, is/was it:

in ADMINISTRATION/PLANNING ☐

as a service PROVIDER ☐

as a SUPPORT person ☐

12. Are you, or have you ever been, a Trustee or Board Member of a health care agency, organization or institution?

NO ☐

YES ☐

13. Are you currently a member of a health advocacy group?

NO ☐

YES ☐

14. Please indicate the age group you are in:

0-20	☐	41-60	☐
21-40	☐	61-80	☐
81-higher	☐		

Service	Where do you think this service should be available?		
	Community	District or Region	One place only in the province
Health & Community Service Teams – to provide some of primary health care (these may include physicians, nurses, nurse practitioners, social workers, physiotherapists, occupational therapists, midwives, community health workers, outreach workers, etc.). ** Note: some primary health care services are noted elsewhere with sections such as "mental health" and "addictions".			
• Family medical care (includes pediatrics and general medicine)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Obstetrical care (pre-natal, post-natal)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Occupational therapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Basic laboratory and diagnostic imaging	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Health Promotion / Protection			
• Pre-natal (education and advice for health of mother and baby before birth)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Post-natal and well baby (education and advice to mother and baby after birth. This includes assessment of development, nutrition counseling and immunization)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Breast feeding support	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Hearing & speech/language	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Parenting programs (support for parents to learn skills to help children develop properly, including help with discipline, learning opportunities for very young children, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Comments

Service	Community	District or Region	One place only in the province
	Where do you think this service should be available?		
• Sexual and reproductive health	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Nutrition counseling (helping people to eat well for the bet overall health)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Addictions (education and promotion related to avoiding or overcoming addictions)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Family planning	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Mental health (education, prevention and advocacy)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Suicide prevention	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Chronic disease education	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Healthy lifestyle (including the place of recreation and physical activity)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Illness and Injury Prevention			
• Communicable disease prevention. (This includes adult immunization, screening, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Education and prevention of non-communicable diseases. (This includes screening for various cancers, promotion of physical activity, promotion of healthy self-esteem, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Safety	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Continuing Care (care and support for persons who need this for living but do not need acute care – including frail and infirm elderly, those who have had serious injuries, persons with disabilities, etc.)			
• Home based care	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Comments

Service	Where do you think this service should be available? Community	 District or Region	 One place only in the province
• Respite care (care for a person with care needs to give a rest to the normal informal care givers).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Nursing Homes and Homes for Special Care	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Adult Residential Centres and Residential Rehabilitation Centres	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Supportive living environments (for persons with some need for care or supervision – including small options and group homes)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mental Health / Mental Illness Services			
• Prevention (includes mental health promotion and education)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Assessment (inpatient / outpatient)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Treatment**			
- acute (inpatient / outpatient)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
- chronic and persistent mental health problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Continuing support, e.g., case management, employment, housing, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Self-help	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Early intervention	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Forensic services (services for those who have committed crimes and are considered to be mentally ill)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Comments

Where do you think this service should be available?

Service	**Community**	**District or Region**	**One place only in the province**
Addiction Services / Substance Abuse (includes gambling)			
Detoxification	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Therapy / counseling	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Structured Treatment - day programs - residential programs	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Adolescent Programs	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Women's Programs	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Emergency Services			
• First responders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Transport to appropriate care centre	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Trauma centre	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Services for Children and Youth			
• Acute and chronic illness specialty care	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Youth (adolescent) health centres	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• School health	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Mental health	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Addictions	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Comments

Service	Where do you think this service should be available? Community	 District or Region	 One place only in the province
Geriatric services / health centres for the elderly – includes continuum of care for elderly people (Continuum means services are available for all aspects of need and that a person can move easily from one kind of service to another)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Palliative care – care and support for people who are dying.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spiritual care	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Complementary medicine / alternative medicines – this includes naturopathy, homeopathy, traditional First Nations medicine, health practices from other cultures	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Where do you think this service should be available?		
Service	**Community**	**District or Region**	**One place only in the province**
Acute and chronic care specialties: These are listed in alphabetic order so there is not grouping or hierarchy. Explanations are very general and intended to give a sense of the meaning, not an exact definition.			
Anesthesia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Burn management	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cardiac surgery (heart surgery)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cardiology (medical care for your heart)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dermatology (skin)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Endocrinology (e.g., thyroid, diabetes)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Family medicine	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Gastroenterology (stomach, intestines, liver, pancreas, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
General medicine	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
General surgery	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Geriatrics (elderly)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Geriatrics - psychogeriatrics (mental disorders in the elderly)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Gynecology (female reproductive organs)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Service	Where do you think this service should be available?		
	Community	District or Region	One place only in the province
Hematology (blood)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Immunology	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Infectious diseases	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nephrology (kidneys)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Neurology (nerves)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Neurosurgery	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Obstetrics - routine pre- and post-natal	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Oncology - medical (Cancer, chemotherapy)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Oncology - radiation (Cancer - radiation therapy)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ophthalmology (eyes)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Orthopedic surgery (bones)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Otolaryngology (ears, nose and throat)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pediatrics (children)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pediatric oncology (Cancer - children)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Reconstructive & plastic surgery	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Rehabilitation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Comments

	Where do you think this service should be available?		
Service	Community	District or Region	One place only in the province
Respirology (lungs and breathing)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Rheumatology (arthritis and rheumatism)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Thoracic surgery (chest surgery)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vascular surgery (veins and arteries)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Women's health and wellness	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cancer care – coordination of services and support for people dealing with cancer.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Care co-ordination – case management, including the technology needed. This includes systems to integrate and coordinate care and services across all levels and lines.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dentistry	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Continuing education for health service deliverers	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Integrated information system – sharing of your health information between parts of the system as needed when your care goes from one part to another.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diagnostic Services (Lab & X-ray, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Policy and standards development for			
• An inclusive health care system	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Health promotion & education	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Health protection	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Comments

Service	Where do you think this service should be available? Community	District or Region	One place only in the province
• Prevention and public health services	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Treatment, emergency & diagnostic services	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Developmental & rehabilitation support services	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Information management	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Research	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Community development	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Healthy community plan	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Group to provide input and local decision-making – e.g., a community health board or district/region board	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pharmacy/drug store	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Disaster readiness	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Subsidized payment for needed medications for those persons who cannot afford them	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Poison control	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Family services	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Comments

Thank you !

Thank you very much for taking the time and effort to complete this workbook! We will use this information respectfully and present a thoughtful summary of it to the government.

As we move toward the next millennium, our wish is that we may all be fully healthy and live safely in this beautiful province.

The Provincial Health Council

Conseil provincial
de la santé

Quels services considérez-vous essentiels à la santé?

Votre guide de travail

Suite 301
1888 rue Brunswick
Halifax, Nouvelle-Écosse
B3J 3P7

Remplir les feuilles blanches, S.V.P.

Les feuilles vert sont optional.

Conseil provincial de la santé

Cher Néo-Écossais,

Le gouvernement de la Nouvelle-Écosse a demandé au Conseil provincial de la santé d'établir une liste de services relatifs à la santé qui devraient être offerts aux Néo-Écossais.

Le conseil a accepté de livrer cette liste de services au ministère de la Santé au plus tard à la mi-mars 2000.

En tant que citoyen de la Nouvelle-Écosse, nous vous demandons de nous aider à établir vos priorités dans le domaine de la santé. Nous avons conçu ce guide de travail dans le but de nous aider à obtenir de vous les renseignements qui nous permettront de compiler une liste qui comprendra les services que vous jugez importants pour votre santé. Veuillez prendre le temps de remplir un de ces livrets. Vous pourrez ensuite l'apporter à l'une de nos réunions publiques ou bien nous le faire parvenir à notre bureau par la poste dans l'enveloppe affranchie qui a été distribuée avec le livret.

Le conseil a entamé d'autres activités pour obtenir des renseignements en plus du sondage qui sera fait grâce à ce livret. Notons, parmi celles-ci, les suivantes :

- l'utilisation des renseignements contenus dans les Plans de santé communautaires créés par les Conseils de santé communautaires de la Nouvelle-Écosse
- l'étude d'activités dans d'autres provinces canadiennes
- l'étude d'activités aux États-Unis et dans quelques pays européens
- l'étude d'activités de l'Organisation mondiale de la santé
- la création d'un conseil consultatif avec une représentation du public ; du système de soins de santé ; des ministères de Services communautaires, de l'Éducation, de la Justice, de l'Environnement, des Sports et des Loisirs ; des organismes professionnels tels que la Société médicale de la Nouvelle-Écosse et l'Association des infirmières accréditées de la Nouvelle-Écosse, des organismes tels

que Santé du cœur, l'Association Alzheimer, Liens communautaires ; ainsi que d'individus qui tiennent à cœur les questions de santé en Nouvelle-Écosse. Le conseil consultatif nous fournira des avis sur les services de santé en Nouvelle-Écosse.
- un sondage d'opinion publique par le biais de rencontres personnelles dans diverses communautés de la Nouvelle-Écosse
- un sondage d'opinion publique par le biais d'une ligne téléphonique sans frais (1-800)
- un sondage d'opinion publique par le biais d'un questionnaire affiché sur le site Web du Conseil de la santé.

Cette liste vous donne une idée de la variété d'outils de recherche que nous utiliserons pour obtenir des renseignements pour votre bien. Tous ces renseignements seront compilés à l'intérieur d'un document qui sera utilisé par le conseil dans le but de conseiller le gouvernement de la Nouvelle-Écosse sur des questions traitant du statut de la santé et des besoins des Néo-Écossais. Ils constitueront une liste des services de santé que vous, les citoyens, jugez importants.

Nous vous remercions de votre participation à ce projet. Les résultats de nos efforts seront communiqués au gouvernement au mois de mars 2000 et ils seront rendus publics à ce moment.

Veuillez agréer l'expression de nos meilleurs sentiments,

Barbara Hart
Présidente du Conseil provincial de la santé

Tom Bird
Président du Comité des services de base

Présentation

Bienvenue et merci !

Bienvenue au guide de travail sur les services à la santé !

Le gouvernement de la Nouvelle-Écosse a demandé au Conseil provincial de la santé d'établir une liste de services relatifs à la santé qui devraient être offerts aux Néo-Écossais. Nous avons besoin de votre aide pour accomplir ce but.

Nous avons consulté les Plans de santé communautaires que vous avez déjà préparés. Nous avons fait des recherches sur ce qui se fait dans d'autres provinces et ailleurs dans le monde. Nous avons déjà demandé à plusieurs fournisseurs de soins de santé quels services ils jugeaient importants, et maintenant nous vous demandons, en tant que citoyen de la Nouvelle-Écosse, quels sont vos besoins lorsqu'il s'agit d'atteindre un bon état de santé et de se maintenir en santé.

Le but de ce guide est de vous aider. Que vous soyez un individu, un groupe, une agence, un organisme, un ministère gouvernemental, ou une communauté, vous pouvez nous fournir les informations qui nous permettront d'élaborer une liste de services qui devraient être offerts au niveau de la communauté, de la région et de la province pour aider les Néo-Écossais à atteindre un bon état de santé et à le maintenir.

Le conseil attache énormément d'importance à vos opinions. Nous anticipons vos idées et vos suggestions et nous apprécions le temps et l'énergie que vous accorderez à ce processus.

Directives pour l'utilisation de ce guide de travail

1. **Utilisez ce guide** pour écrire vos réponses au questionnaire sur les services.

Toutes les réponses nous sont utiles, peu importe si elles sont longues ou courtes. N'hésitez pas à ajouter des commentaires additionnels sur une feuille supplémentaire si vous en sentez le besoin.

2. **S'il vous plaît remplir le formulaire d'évaluation**. Vos réponses nous aideront à perfectionner nos sondages ultérieurs auprès de la communauté.

Informations supplémentaires

Si vous avez des questions au sujet de ce guide ou du processus que nous entamons, veuillez s'il vous plaît téléphoner **John Dow** ou **Louann Scallion Morine** au bureau du Conseil provincial de la santé au 1-800-854-0815 ou, si vous êtes à Halifax, au 424-1639.

Buts des services de santé en Nouvelle-Écosse

La promotion de la santé : promouvoir et améliorer la santé de tous les Néo-Écossais.

Tout en continuant d'offrir de bons soins de santé, nous placerons une importance accrue sur la promotion de la santé et sur la prévention des maladies, des invalidités et des décès précoces.

Un environnement sain : nous assurer que la Nouvelle-Écosse soit un lieu d'habitation sain et sécuritaire

Un bon état de santé sous-entend de l'air, de l'eau et un sol propres, ainsi que des lieux d'habitation, de travail et de loisirs sécuritaires. Nous voulons restaurer, protéger et aménager l'environnement de manière à appuyer un bon état de santé.

Une vie saine : appuyer les efforts des individus, des familles et des communautés dans leurs efforts en vue de mener une vie saine.

Nous allons nous appuyer mutuellement dans notre quête de mieux comprendre les facteurs qui ont une influence sur la santé et nous allons assumer notre responsabilité face aux facteurs sur lesquels nous pouvons exercer un contrôle.

La gestion : nous assurer que les ressources nécessaires pour appuyer la santé sont gérées de manière réfléchie et juste.

Ce sont nos taxes qui financent les personnes, les programmes, l'équipement et les installations qui appuient les services à la santé. L'argent des taxes et les autres ressources seront utilisées de manière ouverte, effective, efficace et redevable.

La participation : engager les Néo-Écossais dans le processus décisionnel qui touche la santé

Toutes les personnes devraient avoir les occasions propices et l'appui nécessaires pour participer au processus décisionnel qui touche à notre santé et au système des soins de santé. Toutes les actions des preneurs de décision sont redevables au public.

La justice sociale : s'assurer que tous les Néo-Écossais ont la possibilité d'atteindre un bon état de santé.

La pauvreté, le chômage, le racisme, l'analphabétisme, la violence, l'isolement rural et d'autres facteurs empêchent souvent certaines personnes de maintenir un état de santé aussi désirable que d'autres. Les politiques que nous mettons en place doivent prendre en considération ces facteurs qui ont un effet sur notre santé.

Les facteurs qui ont un effet sur votre santé

Le revenu et le statut social
Le niveau de revenu et le statut social sont généralement directement proportionnels à l'état de santé

Les réseaux d'appui social
Les personnes qui peuvent compter sur l'appui de leur famille et d'amis ont généralement un meilleur état de santé.

L'éducation
Les personnes ayant un niveau de scolarisation plus élevé ont souvent une meilleure santé.

L'emploi et les conditions de travail
Plus vous avez de contrôle sur votre emploi et vos conditions de travail, plus vous serez en santé.

L'environnement physique
Une exposition à des substances physiques, chimiques et biologiques nuisibles peut endommager votre santé.

L'environnement social
L'appui social, l'isolement, la carence affective, le stress et les capacités d'adaptation ont tous un impact sur votre état de santé.

La supériorité biologique et génétique
Vos antécédents familiaux en matière de santé et de maladie peuvent avoir des répercussions sur votre santé.

Les habitudes personnelles de santé et les capacités d'adaptation
Les choix que vous faites par rapport à l'usage du tabac, à votre comportement sexuel, à vos habitudes de soins de santé et à votre régime alimentaire ont une influence sur votre état de santé.

Le développement sain de l'enfant
La meilleure manière de pourvoir à la santé d'un groupe de personnes est de s'assurer que les enfants sont bien pourvus dès leur enfance. Les enfants bien nourris, éduqués et stimulés deviendront des adultes en santé.

La disponibilité des soins de santé
La disponibilité des soins de santé a une influence minime sur votre état de santé. Le service de santé qui a la plus grande influence sur un groupe de personnes est celui qui éradique les maladies propres aux enfants.

Le sexe
Les femmes ont encore une espérance de vie plus élevée que les hommes.

La culture
La culture joue un rôle important dans notre manière d'envisager la santé, la maladie, le système de soins de santé, notre choix d'un mode de vie et plusieurs autres domaines de notre vie.

Selon vous, où devrait-on offrir ce service?

Le service	Dans la communauté	Dans le district ou la région	A un seul endroit dans la province
La promotion de la santé - Aider les personnes à apprendre comment atteindre un niveau de santé optimum. Par exemple : à l'école les enfants apprennent quels aliments sont propices au maintien d'une bonne santé. Des parents se réunissent pour échanger des idées sur la manière de préparer des collations et des repas sains et à bon marché. Une infirmière vérifie l'état de santé des nouveaux-nés et conseille les mères sur la manière de prendre soin de leur bébé.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
La prévention de la maladie et des blessures - Par exemple : fournir un vaccin antigrippal aux personnes à risque telles que les aînés.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
La protection de la santé - Les mesures qui nous protègent contre la maladie et les accidents. Par exemple : l'inspection des viandes dans les épiceries, l'éducation sur les maladies transmissibles et non-transmissibles, les sections non-fumeurs dans les restaurants, etc.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les soins à domocile - Les soins que vous pouvez recevoir chez vous en cas de maladie ou de blessure. Par exemple : une infirmière vous offre des soins à la maison après une chirurgie.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les soins palliatifs - Le soin et l'appui offerts aux personnes qui sont en phase terminale.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les soins en résidence (Les soins à long terme) - Les foyers pour personnes nécessitant des soins et un appui supplémentaires sur une base quotidienne. Par exemple : les foyers de soins infirmiers.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Les services pour toxicomanes - Les programmes et les services destinés aux personnes qui sont devenues dépendantes de l'alcool ou d'autres drogues. Par exemple : les Alcooliques anonymes.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Valorisation, réadaptation fonctionnelle et appui - Aider des personnes atteintes d'un handicap physique ou d'une incapacité à faire davantage ou a vivre une vie bien remplie. Par exemple : aider une personne à réapprendre à marcher ou à parler après un accident cérébrovasculaire ou autre accident sérieux ayant endommagé le cerveau.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Évaluation de la santé communautaire - Par exemple : le Conseil de santé communautaire fait un sondage auprès des gens de la communauté pour découvrir leurs besoins en matière de santé et il vérifie l'état de santé des gens de la communauté.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Soins communautaires pour malades aigus ou chroniques - Les soins pour malades et blessés offerts par chaque communauté. Par exemple : les médecins qui voient des patients qui sont atteints de maladies de courte ou de longue durée.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Soins régionaux ou de district pour malades aigus ou chroniques - Les soins pour malades et blessés qui sont partagés par un ensemble de communautés dans une région commune. Par exemple : un hôpital de région ou de district qui a un service d'urgence.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Soins tertiaires pour malades aigus - Les soins pour malades et blessés offerts uniquement par des spécialistes, et qui doivent être référés par un médecin généraliste ou un médecin de famille. Par exemple : un chirurgien du cœur à Halifax.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Services qui se rapportent à des autres éléments relatifs a la santé, en excluant les services à la santé (facteurs déterminants généraux relatifs à la santé)	**Pouvez-vous trouver des exemples tirés de votre communauté qui illustrent l'apport de ces services à votre santé?**
• L' emploi	Exemple:
• L'éducation	Exemple:
• L'appui au revenu	Exemple:
• Le logement	Exemple:
• Les réseaux d'appui social	Exemple:
• De l'eau et de l'air propres	Exemple:
• Le transport	Exemple:
• Les loisirs	Exemple:
• Les services de police et de protection contre l'incendie	Exemple:

Ce que nous pensons sur la santé des Néo-Écossais

Quelle importance attachez-vous à cette affirmation ?

	Très importante	assez importante	quelque peu importante	peu importante
1. Les buts des services de santé en Nouvelle-Écosse décrivent un état de santé optimum et les moyens d'y parvenir. Nous savons que notre santé dépend de plusieurs éléments de notre environnement, et non seulement des services de santé offerts (de facteurs généraux relatifs à la santé)	☐	☐	☐	☐
2. Nous devons créer un système qui coordonne les efforts en matière de santé des divers ministères gouvernementaux, des groupes et des sociétés publics ainsi que du milieu des affaires. Ces intervenants doivent partager des informations selon leurs besoins. Ce système facilitera l'accès des gens aux soins de santé.	☐	☐	☐	☐
3. Les services qui nous aident à maintenir et à améliorer notre santé doivent être disponibles aussi près que possible de notre domicile mais nous devons nous rappeler que certains services sont seulement efficaces dans la mesure où il y a une population suffisante qui a recours à ces services.	☐	☐	☐	☐
4. Les communautés doivent être impliquées dans le processus décisionnel qui détermine les services qui touchent leur santé.	☐	☐	☐	☐
5. La population de la Nouvelle-Écosse est une population vieillissante alors nous devons prévoir les services relatifs à la santé en fonction de cette situation.	☐	☐	☐	☐
6. Le gouvernement de la Nouvelle-Écosse doit définir des lois, des politiques et des normes qui vont appuyer les efforts des Néo-Écossais visant à maintenir un bon état de santé personnelle.	☐	☐	☐	☐
7. En Nouvelle-Écosse, nous avons déjà accompli un bon travail dans le domaine de la santé. Mettons-le à profit.	☐	☐	☐	☐

Autres questions de réflexion

Une vision

- Quelle est votre vision de la santé en Nouvelle-Écosse ?

Les priorités

- Si vous aviez le choix de trois services relatifs à la santé dans votre communauté, lesquels choisiriez-vous ? (En autres mots, quels sont les trois services les plus importants pour vous ?)

La promotion de la santé

- Quels sont les renseignements dont vous avez besoin pour maintenir votre santé ? Comment obtenez-vous ces renseignements à l'heure actuelle ? Comment souhaiteriez-vous pouvoir les obtenir dans l'avenir ?

La prévention de la maladie et des blessures

- Que pouvons-nous faire en tant que Néo-Écossais pour améliorer la prévention des maladies et des blessures ?

Un environnement sain

- Selon vous, quelle est la première chose que nous devrions faire en tant que Néo-Écossais pour nous assurer un environnement sain ?

Un mode de vie sain

- Selon vous, que pouvons-nous faire pour vivre une vie plus saine ?

Une gestion avisée des ressources

- Avez-vous des idées sur l'utilisation avisée des ressources dont nous disposons pour promouvoir et appuyer la santé des Néo-Écossais ?

La participation du public

- Qu'est-ce qui pourrait vous motiver à vous impliquer ou à demeurer impliqué dans le processus décisionnel touchant notre santé ou notre système de santé ?

La justice sociale

- Selon vous, quel serait un exemple d'une politique importante qui serait en mesure d'assurer que tous les Néo-Écossais ont la possibilité d'atteindre un état de santé optimum ?

Formulaire d'évaluation : Guide de discussion / Guide de travail et processus de consultation

	non	quelque peu	oui
1. Pensez-vous que le guide de discussion vous a fourni l'information nécessaire pour répondre aux questions de ce guide ?			
2. L'information contenue dans le guide de discussion était-elle bien organisée ?			
3. Les directives sur l'utilisation du guide de discussion étaient-elles claires ?			
4. Les directives pour remplir les questions du guide étaient-elles claires ?			
5.a) Avez-vous participé à une réunion publique ?			
b) Avez-vous l'intention de participer à un réunion publique ?			
c) Si OUI, est-ce qu'il s'agissait ou s'agira-t-il d'une réunion parrainée par le Conseil provincial de la santé OU			
d'une réunion parrainée par un organisme dont vous êtes			
d) Si NON, étiez-vous conscient de la tenue des réunions publiques ?			

6. Comment avez-vous obtenu cette copie du guide de discussion / guide de travail ?

____

7. Avez-vous d'autres commentaires à ajouter à propos de ce guide de discussion / guide de travail ?

____

____

8. Avez-vous d'autres commentaires à ajouter sur la façon générale de procéder par le conseil pour entamer son processus de consultation ?

____

____

Renseignements généraux

Vous n'êtes pas obligé de répondre aux questions qui suivent, cependant des renseignements sur les personnes qui participent au processus de consultation du conseil pourraient nous aider à mieux planifier nos consultations dans l'avenir. Veuillez s'il vous plaît répondre aux questions suivantes :

9. Vous habitez quelle communauté de la Nouvelle-Écosse ?

____

10. Est-ce que vous travaillez ou avez-vous déjà travaillé dans le domaine des soins de santé ?

NON ☐ OUI ☐

11. Si OUI est-ce au niveau :
de l'administration / de la planification ☐
de fournisseur de soins ☐
de personnel d'appui ☐

12. Êtes-vous ou avez-vous déjà été syndic ou membre d'un bureau de direction d'une agence, d'un organisme ou d'une institution de soins de santé ?

NON ☐ OUI ☐

13. Êtes-vous présentement membre d'un groupe d'intervention en matière de santé ?

NON ☐ OUI ☐

14. Veuillez s'il vous plaît indiquer le groupe d'âge à lequel vous appartenez.

0-20 ☐ 21-40 ☐ 41-60 ☐ 61-80 ☐ plus de 80 ☐

Le service	Selon vous, où devrait-on offrir ce service ?		
	Dans la communauté	Dans le district ou la région	À un seul endroit dans la province
Les équipes de santé et des services communautaires – fournir quelques-uns des soins de santé primaires (ceux-ci peuvent comprendre les médecins, les infirmières, les infirmières praticiennes, les travailleurs sociaux, les physiothérapeutes, les ergothérapeutes, les sages-femmes, les agents de santé communautaire, les travailleurs de services d'approche, etc.) **À noter : quelques services de santé primaires sont notés ailleurs sous d'autres rubriques notamment celles se rapportant à la santé mentale et à la toxicomanie.			
• La médecine de famille (y compris la pédiatrie et la médecine générale)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les soins obstétricaux (prénatals et postnatals)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• La physiothérapie	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• L'ergothérapie	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les services de base d'imagerie diagnostique et de laboratoire	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
La promotion / la protection de la santé			
• Prénatal (éducation et conseils sur la santé de la mère et du bébé avant la naissance du bébé)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Postnatal et santé du bébé (éducation et conseils à la mère apres la naissance du bébé, y compris de l'evaluation du développement, les conseils en hygiéne alimentaire et l' immunisation)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Le sein alimentant soutenir	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

	Selon vous, où devrait-on offrir ce service ?		
Le service	Dans la communauté	Dans le district ou la région	À un seul endroit dans la province
• L' ouïe et du discours/ la langue	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les programmes de formation au rôle de parent (appui aux parents dans le domaine des compétences nécessaires pour aider les enfants dans leur développement, y compris la discipline, les stimuli d'apprentissage pour les tout petits, etc.)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• L'éducation sexuelle et santé-reproduction (santé périnatale)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Conseils en hygiène alimentaire (aider les gens à manger mieux pour un meilleur état de santé)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les toxicomanies (éducation et promotion relatifs à la prévention ou au traitement des toxicomanies)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• La planification familiale	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• La santé mentale (éducation, prévention et défense de la cause)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• La prévention du suicide	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• L'éducation sur les maladies chroniques	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Un mode de vie sain (y compris les lieux de récréation et d'activités physiques)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
La prévention de la maladie et des blessures			
• La prévention des maladies transmissibles (y compris l'immunisation des adultes, le dépistage, etc.)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Commente

	Selon vous, où devrait-on offrir ce service ?		
Le service	**Dans la communauté**	**Dans le district ou la région**	**À un seul endroit dans la province**
• L'éducation et la prévention relatives aux maladies non-transmissibles (y compris le dépistage de divers cancers, la promotion de l'activité physique, la promotion d'une saine estime de soi, etc.)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• **La sécurité**	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les soins continus (les soins et le support offerts aux personnes qui en ont besoin pour mener leur vie mais qui ne nécessitent pas des soins aigus – y compris les aînés fragiles et infirmes, ceux qui ont subi de graves blessures, les personnes avec des invalidités, etc.)			
• Les soins à domicile	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les services de relève (le soin aux personnes qui ont besoin de soins afin de donner un repos aux personnes qui offrent ces soins de façon informelle)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les Foyers de soins infirmiers et les Foyers d'accueil offrant des soins spéciaux	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les Centres résidentiels pour adultes et les Centres résidentiels de réadaptation	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les milieux de vie offrant un appui (pour des personnes qui ont besoin de certains soins ou de surveillance – y compris les foyers à clients et options limités et les foyers de groupe)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

	Selon vous, où devrait-on offrir ce service ?		
Le service	Dans la communauté	Dans le district ou la région	À un seul endroit dans la province
Les services relatifs à la santé mentale			
• La prévention (y compris la promotion et l'éducation relatives à la santé mentale)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• L'expertise (malades hospitalisés / malades externes)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les traitements			
- aigus (malades hospitalisés / malades externes)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
- problèmes de santé mentale chroniques et persistants	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Appui continu, par exemple : la conduite des traitements, l'emploi, le logement, etc.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les efforts autonomes (self-help)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• L'intervention précoce	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les services de médecine légale (les services destinés aux personnes qui ont commis des crimes et que l'on considère atteintes de maladie mentale)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Services de toxicomanie / abus de substances (y compris la dépendance au jeu)			
La détoxification	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
La thérapie / le conselling	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les traitements structurés	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
- les programmes de traitements de jour	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Le service	Selon vous, où devrait-on offrir ce service ?		
	Dans la communauté	Dans le district ou la région	À un seul endroit dans la province
- les programmes de traitement en résidence	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les programmes pour adolescents	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les programmes pour femmes	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les Services d'urgence			
• Les secouristes opérationnels	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Le transport aux centres de soins appropriés	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les centres de traumatologie	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les services pour les enfants et les jeunes			
• Les soins spécialisés pour les maladies aiguës et chroniques	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les centres de santé pour jeunes (adolescents)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• La santé à l' école	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• La santé mentale	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• Les toxicomanies	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les services gériatriques / Les centres de santé pour les aînés – comprend les soins de longue durée pour les aînés (les soins de longue durée ou continus comprennent les services rattachés à tous les besoins d'une personne aînée et il est entendu que cette personne peut facilement passer d'un service à l'autre)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les soins palliatifs – les soins et l'appui aux personnes atteintes de maladies terminales	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Le service	Selon vous, où devrait-on offrir ce service ? Dans la communauté	Dans le district ou la région	À un seul endroit dans la province
Les soins spirituels	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
La médecine marginale / Les médecines douces – comprend la naturopathie, l'homéopathie, la médecine traditionnelle des premières nations, les pratiques reliées à la santé tirées d'autres cultures	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Commente

	Selon vous, où devrait-on offrir ce service ?		
Le service	Dans la communauté	Dans le district ou la région	À un seul endroit dans la province
Les spécialisations pour des soins aigus et chroniques: Nous vous présentons cette liste sans ordre hiérarchique et sans groupements. Les explications sont très générales et sont présentées dans le but de faire ressortir le sens plutôt que de viser une définition exacte.			
Anesthésie	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Brûlures (gestion des brûlures)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Cardiochirurgie (chirurgie du coeur)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Cardiologie (soins médicaux pour le coeur)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Dermatologie (la peau)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Endocrinologie (par exemple: la thyroïd, la diabète)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Médecine de famille	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Gastroentérologie (estomac, intestins, foie, pancréas, etc.)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Médecine générale	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Chirurgie générale	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Gériatrie (aînés)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Gériatrie-psychogériatrie (désordres mentaux chez les aînés)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Gynécologie (organes reproducteurs des femmes)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Hématologie (sang)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Commente

Le service	Selon vous, où devrait-on offrir ce service ? Dans la communauté	Dans le district ou la région	À un seul endroit dans la province
Immunologie	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Maladies infectieuses	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Néphrologie (reins)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Neurologie (nerfs)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Neurochirurgie	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Obstétrique-routines prénatales et postnatales	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Oncologie-médicale (cancer, chimiothérapie)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Oncologie-radiation (cancer, radiothérapie)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Ophtalmologie (yeux)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Chirurgie orthopédique (os)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Oto-rhyno-laryngologie (oreilles, nez et gorge)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Pédiatrie (enfants)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Oncologie pédiatrique(cancer chez les enfants)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Chirurgie de reconstruction et chirurgie plastique	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Réhabilitation	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Pneumonologie (poumons et respiration)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Rhumatologie (arthrite et rhumatismes)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Commente

	Selon vous, où devrait-on offrir ce service ?		
Le service	Dans la communauté	Dans le district ou la région	À un seul endroit dans la province
Chirurgie thoracique (chirurgie du thorax)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Chirurgie vasculaire (veines et artères)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Femmes (santé et bien-être intégral de la femme)	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Soins pour le cancer – coordination des services et de l'appui offerts aux personnes qui font face au cancer.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Coordination des soins – la gestion des cas, y compris la technologie nécessaire. Comprend les systèmes qui permettent l'intégration et la coordination des soins et des services offerts à tous les niveaux.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
La médecine dentaire	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
L'éducation permanente pour les dispensateurs de services relatifs à la santé	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Système d'information intégré – le partage d'informations relatives à la santé entre les différentes composantes du système afin d'accommoder les personnes qui doivent avoir recours à plus d'une composante du système.	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Services de diagnostique (laboratoires	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
L'élaboration de politiques et de normes relatives :			
• à un système de soins de santé global	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• à la promotion et à l'éducation dans le domaine de la santé	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• à la protection de la santé	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Commente

	Selon vous, où devrait-on offrir ce service ?		
Le service	**Dans la communauté**	**Dans le district ou la région**	**À un seul endroit dans la province**
• aux services de prévention et de santé publique	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• aux services de traitement, d'urgence et de diagnostique	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• aux services d'appui relatifs à la valorisation et à la réhabilitation	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
• à la gestion de l'information	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
La recherche	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
La développement communautaire	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Un plan de santé communautaire	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Un groupe qui a le mandat de fournir de l'input et de participer au processus décisionnel – par exemple un conseil de santé communautaire ou un conseil régional ou de district	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les pharmacies	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les plans d'urgence en cas de catastrophe	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les paiements subventionnés pour défrayer le coût des médicaments pour les personnes qui n'ont pas les moyens de se les payer	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Le contrôle de l'usage des poisons	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Les services à la famille	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non

Commente

Merci !

Nous vous remercions chaleureusement d'avoir mis le temps et l'effort nécessaires pour remplir ce guide ! Nous utiliserons les renseignements que vous nous avez fournis de façon respectueuse et nous présenterons au gouvernement un résumé pertinent des résultats.

En ce début du nouveau millénaire, nous souhaitons que nous puissions tous apprécier une bonne santé et vivre en toute sécurité dans notre belle province de la Nouvelle-Écosse.

Le Conseil provincial de la santé

Appendix 4

Public Meetings

4.1 List of Meetings
4.2 Facilitator's Guide
4.3 Meeting Transcripts

Provincial Health Council

Core Services Public Consultation

Public Meetings

Meeting List

January / February 2000

Suite 301
1888 Brunswick Street
Halifax, NS
B3J 3P7

Appendix 4.1 List of Meetings

- **Annapolis County** - Bridgetown High School, 26 Jan, 7pm
- **Antigonish County** - St. Andrew's Jr. School, 14 Feb, 7pm
- **Cape Breton County**
  - Louisburg - Fire Hall, 15 Feb, 7pm
  - North Sydney - Fireman's Club, 16 Feb, 7pm
  - New Waterford - Kin Centre, 20 Feb, 7pm
  - Glace Bay - BayPlex Community Hall, 21 Feb, 7pm
  - Sydney - Steel Worker's Hall, 23 Feb, 7pm
- **Colchester County** - Bible Hill Village (Fire) Hall, 4 Feb, 7pm
- **Cumberland County** - Amherst, EB Chandler Jr High, 7 Feb, 7pm
- **Digby County** - Weymouth Legion, 20 Jan, 7pm
- **First Nations Communities**
  - Bear River Community Hall, 22 Feb, 10am
  - Millbrook Community Hall, 23 Feb, 1pm
  - Eskasoni, Gabriel Centre, 24 Feb, 1pm
- **Guysborough County** - Guysborough Fire Hall, 17 Feb, 3pm
- **Halifax County**
  - Dartmouth - St. Peter's School, 31 Jan, 7pm
  - Dartmouth - North End Community Clinic, 1 Feb, 7pm
  - Musquodoboit - The Birches, 10 Feb, 7pm
  - Halifax - St. Pat's High School, 4 Feb, 7pm
  - Spryfield - J. L. Illsley High School, 15 Feb, 7pm
  - Sackville - Sackville Heights Jr. High, 10 Feb, 7pm
- **Hants County**
  - West Hants - Windsor, Hants Community Hospital, 26 Jan, 7pm
  - East Hants - Upper Nine Mile River Fire Hall, 27 Jan, 7pm
- **Inverness County** - Inverness Academy, 23 Feb, 7pm
- **Kings County** - Kingstec, Kentville, 27 Jan, 7:30pm
- **Lunenburg County** - Bridgewater, Nova Scotia Community College, 31 Jan, 7pm
- **Pictou County** - Hector Centre, Pictou, 17 Feb, 7:30pm
- **Queens County** - Liverpool Regional High School, 10 Jan, 7pm
- **Richmond County** - Strait Richmond Hospital, Evanston, 22 Feb, 7pm
- **Shelburne County** - Shelburne Fire Hall, 12 Jan, 7pm
- **Victoria County**
  - Neil's Harbour, St. Andrew's Parish Hall, 24 Feb, 7pm
  - Baddeck Court House, 21 Feb, 3pm
- **Yarmouth County** - Yarmouth Regional Hospital, Bluenose Room, 13 Jan, 7pm

Provincial Health Council

Core Services Public Consultation

Public Meetings

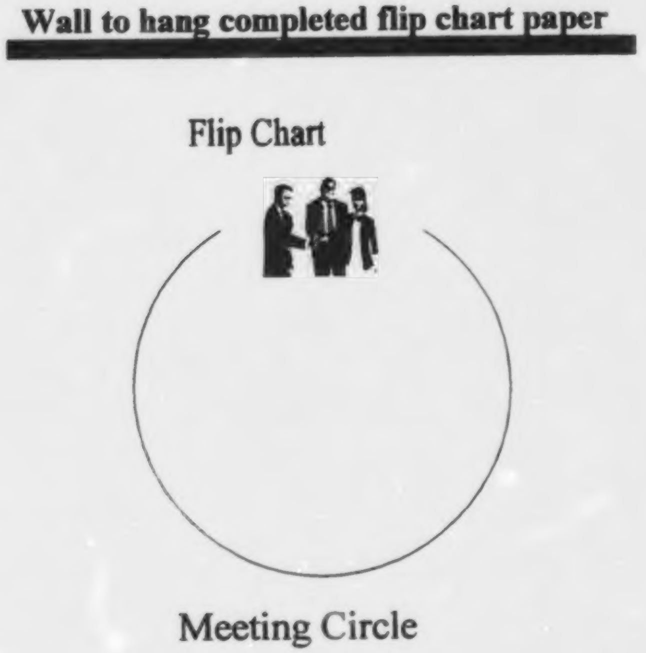
Facilitator's Guide

January / February 2000

Suite 301
1888 Brunswick Street
Halifax, NS
B3J 3P7

Room Set-up

Try to arrange seating for participants such that they can sit in a circle: around a table if possible and numbers permit, or in a semi-circle of chairs. There should be a break in the circle so that participants can see flip chart or the flip chart paper on the walls.



If the room is an odd configuration, or if there are more people than can fit comfortably around a table, do the best you can to make sure people in the meeting are talking to each other as well as the facilitator. Make sure a small note pad and pencil is available for each person, either on the table or on the chair (if there is not enough table space available for everyone).

Try to have one wall available for putting up flip chart paper. On that wall, on the left side, put up the banner with "HEALTH"; on the right side, put up the banner with the word "SERVICES" with three columns of flip chart pages with the titles, "Community", "Region/District" and "Province" at the tops.

If the room has already been set up theatre style in preparation for the meeting, ask permission to change the arrangement as described above.
(Principle: People are talking in community and not as isolated individuals.)

Opening the Meeting

Once the people in the group have settled down in their places and the local CHB chair or meeting organizer has introduced welcomed the participants and introduced you, it is time to introduce yourself, the other person with you, the Provincial Health Council and the purpose of the meeting. The process should go something like this:

- Chair of the meeting (local CHB chair, or other organizer of the meeting)
  - welcomes everyone,
  - may say a few words about the role of the Provincial Health Council (to advise the cabinet on health issues on behalf of Nova Scotians) and the purpose of the meeting (to gather input from Nova Scotians about core services that promote and support health)
  - and introduces the two PHC people in attendance.

- Facilitator addresses group:
  - introduces self a little more fully (where in Nova Scotia you come from, your role with the PHC) and introduces the other PHC person in attendance (same information).
  - re-introduces purpose of the meeting in terms of
    - role of the Provincial Health Council
    - the mandate from government (insert)
    - how this meeting fits in with the task (This meeting is part of a series of meetings being held in all parts of Nova Scotia for this purpose. In addition to public meetings like this one, the PHC core services steering committee has studied core health services in other parts of Canada and the world, has sent round a workbook which will give us input — we hope all of you have completed one of these; if you haven't, there are extras at the entrance — and we have worked with an advisory committee of experts from different government departments and from CHBs around the province.)
  - describes how this meeting will progress:
    - you will be asked to tell us what good health is to you and we will record your main ideas
    - we, as a group, will use those ideas to talk about what kinds of services are needed to make this community more healthy. These services will also be recorded on the flip chart.
    - we'll do that all on flip chart paper that will be posted on the walls so that we can all see that your thoughts have been recorded.
  - describes what will happen with this information after the meeting:
    - we will be asking you to respond to some questions related to services that support health in your community, and we will be recording the answers on flip charts.
    - whatever is on the flip charts will be entered in a report as the input from this meeting.
    - this information will be compiled with that of other groups
    - a summary of this input will be put together with all of the input from other places and

with all of the information gathered, to make up a recommendation to the Premier about core services to achieve and support health for all Nova Scotians.

- asks for any questions from participants — "What questions do you have about what we're going to do?"

Facilitating the Input

Plan A - 15 persons or less

- Wait for all process and purpose questions to be answered
- Ask participants to think for a minute about the following questions (which you have pre-printed on a flip chart page and can show them at this time:
  1. **"What does it mean to you to be healthy?"**
  2. **"What for you is a healthy community?"**

  and to jot some key words or ideas down on their pieces of paper.
- After 5 - 7 minutes (check if anyone is still furiously writing), ask that each person in turn share with the group their responses, while you (or the other person from the council) writes down key words or phrases down on the flip chart. Make sure that these key words or phrases are in the words of the participant. If what they say is difficult to summarize in their own words, ask them to give you some words that will describe what they are saying.
- If what one person says is a reasonably exact repetition of what someone has already said, ask if you can put a check mark by the first comment or if the person wants to have it noted separately.
- As soon as each flip chart page is full, post it on the blank wall on the left side.
- When all persons have given their ideas, ask the group to review what has been posted and ask if there is anything else someone wants to add.
- Now ask participants to consider the question: **"To be healthy in this way, what services do you need to have available to you — in your community, within a district or region, or provincially — that will help you to become or stay healthy."** — Have this printed on a flip chart page and show it for this part of the discussion. Ask them to note their thoughts on their note paper.
- When they have finished writing, ask each in turn to share one service they have noted and where they believe it should be delivered. Note it on the appropriate flip chart column on the right side of the front of the room. When all ideas are exhausted, ask the group to review them for completeness and so they can choose what for them is most important.
- Ask the participants each to take a coloured marking pen and to put a dot, check mark or star by those three services which they believe are most important for their own health and the health of their community.
- When completed, add the numbers by each service and summarize the results for the participants. Ask the participants if they have any comments about what the results show. Reinforce that all ideas will be used in developing the recommendations to the cabinet — none of it will be lost.

Plan B - More than 15 persons

- Wait for all process and purpose questions to be answered
- Make sure all participants are part of a group comprising no more than 10 persons (ideal is 7 - 8 persons)
- Hand out small group instructions for Discussion 1, so that each person has a copy
- Go through the instructions, especially those describing the job of the small group facilitator/timekeeper and the recorder/reporter.
- When all instructions are understood let the groups begin discussion and circulate to answer any questions — make sure you keep track of time along with the small group facilitators.

Closing the Meeting

- Thank the participants for their contribution to the discussion and for the input that will be used to develop the recommendations to cabinet.
- Explain what will be happening with the information at this point — especially whether their group will be able to see the summary of their input — and when and how the final recommendations will be available.
- Indicate the available workbooks and encourage those who have not yet completed them, to take one, complete it and send it in.
- Thank the host (CHB chair, or meeting organizer) for her/his assistance in making this possible and wish them all a safe and healthy new year/millenium.

Instructions for Group Discussion # 1

In your group, appoint one person to be discussion **facilitator / timekeeper** and one to be the **recorder / reporter**.

The task of the facilitator/timekeeper is to:
a. Make sure each person (including the facilitator and the recorder) has a chance to speak to the questions
b. Keep track of the time, making sure each person has enough time to say their piece.

The task of the recorder/reporter is to:
a. Keep notes that the Provincial Health Council can use afterwards of what each person says, trying to use the main words that the person used.
b. Report the main points of your group to the larger group when that is asked for.

In your small group:

1. Take 3 minutes the people in the group to make some notes to yourselves on the paper provided in answer to these questions:
   - What does it mean to you to be healthy? .
   - What for you is a healthy community?

2. Introduce yourselves to the others in the group. (7 minutes maximum)

3. Each person tell the group your answers to the two questions:
   - What does it mean to you to be healthy?
   - What for you is a healthy community?

   — 2 minutes each.

4. Be ready to have your thoughts presented to the large group by your reporter

Instructions for Group Discussion # 2

In your group, please appoint a different **facilitator / timekeeper** and **recorder / reporter** from those you had during the first discussion.

1. Take 3 minutes to write down on the paper provided your answers to the question:

   > **"To be healthy in this way (from discussion #1) what services do you need to have available to you — in your community, within a district or region, or provincially — that will help you to become healthy or stay healthy?"**

2. Each person share your thoughts on this question with your group, with the recorder taking notes of the key words. — 1 minute each

3. Be prepared for your thoughts to be presented to the large group by your group reporter.

List of Supplies

Note pads
Pencils
Banners: Health
    Services
    Community
    Region/District
    Province
Batch of marking pens
Prepared flip charts with two sets of questions

Plan B supplies

Small group task discussion/instruction pages

Some Answers to Possible Questions

Definitions

Community: a group of people identified as living within and having a sense of belonging to a geographic area who share resources, facilities / services and/or share common goals, needs and interests.

Region/District: a cluster of communities

Province: a cluster of regions/districts

Questions / Challenges

1. You have a number of people who want to make formal presentations to the Council through this event.
   - We will allow time at the end of the meeting, if you (the requester) feel that the issues you want to raise have not already been adequately brought out during the process of the meeting.

2. The participants in the meeting spend a lot of time telling of individual problems or on personal agendas.
   - Our task here is to gather input from you about the shape and characteristics of the health system, so we can advise the government based on what we hear and improve the system that these individual problems become less.
   - Turn the complaint around: if a person talks of how long her mother had to wait for a mammogram, suggest that we want to improve access to cancer screening.

3. Participants ask about the boundaries of the new districts.
   - Show the map that gives the configuration of the new districts, being careful to show how this particular area fits into the picture
   - Note that the key issue is to look at the determinants of health in each community. The location of the new district boundaries and the hospital is important in the context of how it helps improve health in the community.

4. People are confusing the Provincial Health Council with the Department of Health.
   - Reinforce the role of the Provincial Health Council as being advisory to government as a whole, as stated at the beginning of the meeting.

5. People have questions about Community Health Board legislation and the role of CHBs in the new districts
   - answer factually, don't give opinions

Amherst

- Multiple chemical sensitivities
- Quite sick outside home
- Lack of treatment for environmental illness in Nova Scotia
- There has been no treatment for environmental illness in Nova Scotia since 1992
- Building built to treat and has ended up as a research facility - on waiting list for 8 years, had to leave Halifax to move to Cumberland County
- Going to New Brunswick where she gets treatment and pays for it
- Know there are problems with HCS but doesn't know any other illness which isn't paid for in system
- Government needs to address this
- Unethical to put money into research if there is no money being put into treatment of the illness
- USA - 1,500 doctors with training
- In Nova Scotia there were 2 - 1 just died
- The ones here can't provide full treatment
- What money does exist needs to be put into treatment
- The problem is growing but the people are invisible because they don't come out to meetings

- Does home care
- Physiotherapy is blind
- Covers 2 counties
- Sponsored by Arthritis Society, not the government
- Should be part of HCNS and publicly funded
- HCNS - should provide support to people in home including personal care worker, nurse, physiotherapist, occupational therapist, ADL, speech therapist
- We see - total hips, knees, shoulders
    - Frail elderly, CVA, MI, pneumonia
    - MS, Parkinsons, CVA - no resources to help them
- HCNS is major topic - need to have full package to go into home
- Program - HC physiotherapy
    - Would be hardship for client to get to regular clinic (criteria)
    - Nova Scotia not completely covered

- Shortage of general practitioners in Amherst area
- Has to go to Sackville for general practitioner
- Has to go to Truro for diabetes
- Child with diabetes
- Husband waited 5 hours in outpatient department
- Broken toe
- Nurses - overwhelmed, tired, run ragged
- No pediatric consult here
- Shortage of doctors, shortage of specialists, need hospital and services, population - 10,000

- Access to Moncton closer than Truro but Northern Regional Health Board won't refer to New Brunswick
- Catchment area - approximately 30,000 with overflow from Westmoreland County, New Brunswick

- A lot of people to go outpatient department
- They should have 2-tiered emergency - trauma
  - Ambulatory care
- This would free up emergency for the really serious issues
- People would still be able to see doctor but may have to wait a bit longer

- Should have clinic access off hours
- Better use of resources
- Streamline who gets seen with what

- All services under primary health care including acute care
- Need faster acute referrals to specialists. How can this happen?
- Friend waited 3 months for bypass
- Need to speed up the referral process
- Shortage of doctors, nurses, equipment

- Amherst
- Shortage of equipment, trained specialists
- Staff very caring
- Has to go to Halifax and Moncton for additional care
- Mom just got out of hospital - 71 years old, has to travel to Halifax and Moncton - should be services here for elderly - our population is aging
- Nurses and doctors have no back up
- Why can't we have all the services in Amherst
- Shortage of doctors - but they have increased in number recently

- Large percentage of population has to go out of town for general practitioner
- Should have visiting pediatrician once a month
- Should have a visiting orthopod monthly
- Should have visiting cardiologist regularly
- If we can't make it to Halifax we die
- Can't even be casted here
- Could be sent home overnight with broke rib
- Not getting the basic care
- People waiting for 1 year for bone density test or drive to Lunenburg
- Equipment at Amherst
- Nurses glad they finally had electronic meters

- Accessed last year for first time
- 20 doctors, 4 specialists

- Technology wonderful
- Need to improve communication
- Scheduled for 2 CAT and 2 MRI
- ____ up 7 times in 8 days to provide information and wait for booked tests
- There needs to be a focus on the patient
- We don't look at things from the patient's perspective
- We have the technology - use it

- Concerned about services wife had to access
- No oncologist
- Referral Moncton
- Surg in Moncton
- Radiation referral to Halifax or St. John
    - Had to stay in Halifax 5 weeks for 2 minute treatment
- Medical referral to Halifax costs extra $6.00 for tolls
- Moncton was doing New Brunswick, Nova Scotia, PEI
- Should have it here
- Nova Scotia just hired 7 more oncologists. We only had 2
- Waiting list 6 weeks in Moncton
- Waiting list 2 weeks in Halifax
- Also came down with heart problem
- Amherst referred to Moncton to see Dr. Brown
- Sent to Moncton by ambulance
- Returned to Amherst by ambulance
- Ambulance bill - 2 trips
- Called local administration at Highland View
- Called EMC - $60.00 or $30.00 depends
- Okay to go to Moncton
- Don't like to pay extra
- Nova Scotia and New Brunswick need to get together
- IV drip equipment is not compatible in Nova Scotia and New Brunswick
- 2 hospitals in Moncton
- Oncologist/cardiologist not here
- Should be someone here
- Shouldn't be user fees for ambulance service
- If we had the services here and went elsewhere charges would be appropriate but not if the services are not here
- Bring relative to hospital - can't do brain scans, etc. Whip to Moncton or Halifax
- Nephew died on way to Halifax
- Brother sent to Moncton and died before his reports got back
- We need either a full service hospital or we shouldn't pay for transportation to where the services are

- Write to your MLA's and Minister of Health
- We will be losing services here
- We serve 32,000 and 7,000 from Western New Brunswick

- The services are not here
- People have to stand up for their rights

- We will always have the core service
- Travel elsewhere is a fact of life
- Moncton is 30 minutes away
- Government should formalize with New Brunswick for specialty services to be shared with Cumberland County
- Can sit in waiting room in Sackville with your neighbours
- Need shuttle service for testing rather than using ambulance
- Centralized booking process needed

- Dialysis patients (____)
- Had to travel to VG or George Durlont 3x7
- Costly excursion and difficult trip as well
- Quite a bit of lobbying May, 1999 - satellite program at Springhill Hospital to serve Cumberland County
- Because Springhill or Amherst have no nephrologist, some patients still require transport to Moncton or Halifax
- In future with earlier diagnosis and our aging population, we will probably have more people needing dialysis
- Government should keep this a ----, expand service in Springhill, bring nephrologist to Amherst for clinics
- Expand haematolysis service and bring in nephrologist

- Used to have orthopod for 4-6 weeks
- Why can't we have these specialists here on a regular basis

- Home care class
- Out on practicum with VON home care workers
- Stories that are unbelievable
- The students won't work with VON under any circumstances
- There is a need for more PCW in the community
- Growing aging population
- We need more PCW. VON have limited homes to provide service

- Emergency services problems
- Used to have 5 services - now only 1
- Oxford - best equipped ambulance service east of Montreal
- Increased cost $15 million a year EHS
- Service decreased
- Mother fell Parrsboro 1 ½ mile
    - Sent to Amherst via ambulance from Springhill
- Previous ambulances provided better coverage at less cost

- Halifax making decisions about rural Nova Scotia is a problem

- Cumberland County is as big as PEI
- 911 changed road and street names so no one can find anyone anymore
- To fix
    - Go back to the way things were

- Reference Blueprint Report
- Majority of Nova Scotia would accept care from a number of providers, not just MD's
- Example, nurses, dieticians, pharmacists, etc.
- This hasn't happened
- Still doctor only way into system
- Support nurse practitioner projects
- 51% of patients seeing doctor really need doctor. The rest need a mother, wife, nurse, etc.
- Set up education programs for people who ____ needing to access multiple providers
- Doctor in Britain
    - 7,000 patients, 7 nurses working for her
- We need to see this in Nova Scotia
- Need more educational programs like Heart to Heart or Breath Easy Program
- These programs are usually provided by volunteers (usually nurses)

- Need accessibility to primary care
- My purpose - there should be an RN in every doctor's office in the Maritimes
- We would be healthier and most cost effective
- Less technology and more promotion and prevention
- At MSI expense
    - Focus on what we have
    - RN's could be better used
- Europe - better promotion and prevention provided by nurses
- Don't think the doctor has the only answer
- A good number want to practice good medicine
- Money/money/money
- Get rid of government in trying to fix health care. Tell this to Dear John (I've already told him 3 times this year)
- Waiting for 6 weeks to see doctor is deplorable
- We have enough - are they all working full-time
- Are all the specialists providing the services they should
- Long-term care facilities need to be looked at
- Physiotherapist who spoke earlier should be commended for the service they provide to long-term care facilities, prisons, door to door
- Money - you can get it but you need to work hard to make sure the real issues are addressed

Suggestions to meet needs:

1. Nursing clinics - walk-in or appointment, 24 hour service
2. Use doctor's office or centre public health off hours
3. School Nurses - re-instate

4. Mobile Wellness Units: Screening
5. Seminars; specialists to outpost areas/support groups
6. Better training for home care givers
7. Physio - mobile (home care and institutions)
8. Education: re: technical medicine to institutions, cost-effective prevention, life style changes, healthy living

Quick - fix, take a pill, do tests

- Policies are different in ____ area - access to lab work results need to be addressed
- Patients with FD should carry their own medical records
- You have to take responsibility for your own health

- Look at graph from 10 years ago. 10% for HP and IP
- Now about 1.5%
- No reason why we have to go to IWK/Grace for paps

- Wife is PCW in long-term care in Amherst
- We started work at 16 - done just about everything
- PCW's deserve recognition for their service
- PCW's should be better paid
- Provide a service that I couldn't do
- Give them a big boost in wages
- They also need to be supported
- Better use of all health related resources

- Doctor in town - trained in Poland
    - Was able to do orthopaedics there but not here - why?

- Was at QEII many times
- Has worked with nurse practitioners
- Why can't we have them in Amherst
- Project in Springhill
- Don't tie their hands
- Don't underutilize them
- Are too task-oriented in acute care and need to be able to do the education and the counseling

- Halifax needs to know that Amherst is cut off by Cobequid Pass and the New Brunswick border
- Make sure Halifax hears this
- Could the press do the report in sections, as the review process did before?

- Get a plug in for a new hospital
- Planning for years
- Last place in province
- Immense planning process - redesign

- Facility was planned and designed around outcomes
- Finance wasn't connected to health
- Recommend communication between government departments - so they know the design process for Highland View was outcome driven, not pie in the sky
- Don't change horses with each government

- Process was patient-focused and driven, not administration/waiting, etc., driven
- Investment in time and energy by staff and community was immense
- Are losing the commitment as cuts are made

- Will save money in long run if you put the system in place the way the community and providers designed it

- How are the patients going to suffer with the delay?

Antigonish

- A cynicism about the process that tries to get government to act on behalf of people
- The communities don't have the ear of the government
- The business world has much more power
- When community sits down like this to talk about moving, it isn't felt that the government is on our side
- This area is largely rural, we have lost the things like schools and post offices here, the government presence is gone, do I really trust the government, as I am filling this book out
- The Mental Health Review Committee, the finance group, etc all doing the same thing, consulting the public, why?"

- Member of provincial steering committee on Mental Health, is there duplication here, or are we doing just physical acute care stuff?"

- We talk about mental health if it comes up from the group

- I think another psychiatrist is needed in this community. We also need a drop in centre for people with mental illness. There are a number of people here not being serviced in terms of programming service, going from coffee shop to coffee shop
- Also need a sheltered workshop in this area
- The baby boomers are getting older, we need to plan for Alzheimer's disease, many people will need the services of mental health, in this community many things were here and are now gone
- The hospital is turning off lights to save money, like walking into the twilight zone
- There is no transition from the hospital to the community, there is no opportunity to integrate into the community from the hospital
- I'm a mental health consumer myself, at 17 put in hospital in Halifax, there was nothing in place

- We need more community mental health nurses as case workers, to free up the psychiatrists and other workers to carry out the mental health services.

- Are we looking at cookie cutter approach or a provincial plan? With individuals community concerns being addressed.

- Not using nurse practitioner

- What we are talking about here is treatment, remedial, etc. what are we hearing about promotion, prevention, are we moving at all to that direction
- The government needs to hear that we want to, live in communities that promote our health, and for the government to put money that would recognise the shift"

- Less than 4% goes into health promotion. We well know that nutrition, clean water, etc., is good stuff, we don't have many incentives, or things that are accessible to many people for lifestyle choices, costs money to exercise, need people trained, in larger numbers, having free clinics for people to come and get counseling on diet, exercise, etc.
- Hard to be motivated, need one on one
- That area is totally lacking, those factors are the biggest factors in prevention of heat disease and stroke, those things that cost millions and millions of dollars
- Cardiac exercise 3 times per week you probably don't need to do cardiac blood work, it is not promoted

- To what extent have the community health plans talked about it?." It is beyond talking about healthy eating, we also need to address the barriers to getting the food, preparation of the food, etc. more than just getting the message out, also need to provide the education to lead a lifestyle healthier

- The importance of the allied professionals involved in the promotion of wellness, increase these

- People know where they can go to access healthy food, in a dignified way, they have the resources to do that, elderly people know they have the resources
- Living in a community where they know this can happen. Isolated people need to access, the services may be there, but they are not connected, need to know the community is able to take care of its own people, the role of the community health board to lead this process, identify what the issues are and how the community can work together to make that happen

- Having the access is great but you also need the funds, basic income and security, not isolation
- ____ gets to mental health issues we know are lacking in our community, things are not working well so we need the services in order to build the healthy community

- Canada's food guide is good but if you can't afford to buy the food they aren't much good, need liaison with Community Services, mental health, Health etc to make sure there is enough resources, need comm health nurses,

- Go into the schools with organisations to give presentations related to promoting overall health, holistic, saying to primary kids, every day I go for walk, so should you, we need to do this with the kids.

- We have school system where kids go 4/5 months without phys education and then have it every day for 4 months" " the Department of Education is creating an environment where health is not promoted, we need to have promotion in schools, look at the school cafeterias

- The WHO, points out 4 utilities, clean air, water, food, housing, - very controlled by the market, if you can't afford them you can't access them, as human we should have basic right to these.

- In Arctic - people were blessed with an extra whale - food is shared and not sold - if you did this here, Sobey's would have an fit

- Palliative care - 1983 at St. Martha's by Maureen MacDonald
- Until 1991 I didn't realize what palliative care meant to a individual or family
- 1991 my husband was diagnosed with pancreatic cancer
- Friend from Halifax retired, provided guidance in palliative care
- Died in Jan 1992
- Respite care provided for family
- 1994 went to Royal Victoria Hospital in Montreal and in Ottawa the Elizabeth Broulier
- 1995 became volunteer assistant Coordinator of Volunteers at St Martha's
- As St. Martha's became part of Eastern Regional Health Board, centered around hospitals and gave service into the community
- Technology meant care could go to the patient if a trained RN was there
- Neil's Harbour, Inverness, Cheticamp, etc., became model for other areas.
- As government talks about changing health care what does that meant to palliative care
- Now advise and follow through for cancer patients is helpful even for remission patients
- Ask that palliative care be allowed to continue AND BE ENHANCED

- Palliative care - volunteers
- Written submissions

- The model we use for palliative care could be used for other services

- On receiving end of palliative care and to hospital in the home
- Written submission

- I don't understand why hospital in the home isn't being used in the rest of NS, it is cost effective, cost efficient, etc.

- Employee of St Martha's, and now a user of both palliative care and hospital in the home

- Why are we wasting, why don't we expand the hospital in the home across the province. There seems to be a jealousy, if Halifax does it no one else will, or if Sydney does it, no one else does

- This builds on the strength of the community

- If Halifax tried it we would have to buy it

- Hospital in the home is about 30% of hospital care

- Long-term care - known fact that long-term care beds are needed, acute care beds are being held up by people awaiting placement, here

- Not just acute care beds but ripple effect, people shipped off to any facility that has a bed, hard on the client, psychologically, on individual and family, individuals deteriorate faster, family not able to visit frequently, 10 daily at St Martha's right now holding up beds, no money here for expansion, need plan for development of long-term care facilities, need seamless continuum of care, also in Blueprint

- Provider, changes in health care system, cut backs, acuity levels increasing, staying in homes longer and care is heavier, access to acute care services is more difficult, e.g., cataract, no longer admitted, now get the service and return to the home, increasing the workload on the staff, numbers and educational levels of staff are suffering as acuity increases and staff can't keep up

- Funding for adult day programs needs to be put into place, use the expertise of the people in the long-term care, no provincial funding right now

- Stress as a result of shortages, especially in long-term care as numbers decrease in staff, unable to attract and keep staff, the staff we do have to look after many more people who are becoming heavier and heavier in care requirements,

- Respite care - need for those who are taking care of the mentally ill as well as physical, many people return to the family home, need continuous care, we have a lot of good programs but we need to make good use of, don't necessary need more dollars, just use the resources properly

- People caring for children, parents, people with disability, etc., requires a great deal of input, leads to stress of care givers, need to support the givers of the services

- This Wednesday at Province House - press conference with Minister of Health to release the Health Initiative on Family Violence, also documents coming from Justice, education, etc.

- If the government doesn't push this document as much as drunk driving the health of people is very seriously affected, approximately $4B per year in family violence

- Cover life cycle, and don't ignore the kids, here Kids First, started with federal money and little provincial input, need to develop the clinics, excellent models in this province, feds may withdraw funding and we will lose these, funded through Health Canada, Prenatal Nutrition and Capsea, (Cretien)

- Baby boomers, increasing number of diabetics, excellent clinic here in Antigonish, we need to be aware that this will happen, we use good model of education

- Health is more than Department of Health - concern that we don't or can't address all the departments

- We shouldn't be surprised that the communities have it together, it breaks down as you move up the ladder

- Message to government, look at a process of health impact assessment build on the determinants, look at the examples from this region the PATH Project, St Ann's, Canso, Whitney Pier, out of Antigonish

- Youth centre at Antigonish just opened, a drop-in centre, a need was felt for a long time, a lot of you involved in the planning, the centre has temporary funding. Youth Centre in Port Hawkesbury operated for some time and served a big need but just closed their n\doors. There is a big need and it serves a purpose that is very necessary, Adolescents Coming Together for Change Youth Centre, service a big need a positive step

- Schools are closed at 3 o'clock, never used after hours, ACT for Change - great for town kids, but is inaccessible to kids in the outlying areas, there is nothing for them unless their parents can drive them into the town

- Communities can be very resourceful, can plan programs and services to meet the needs of the residents, they can often do it with a bit of seed money, government should support and nurture communities that are trying to do their own thing, help the communities to build on what they are trying to do in their own communities

- Good to consult with the community, when I see the government going to Harris politicians they will stop everything and move it backward, leave the Harris people in Ontario, we don't need them to get us on our way

- Doing research on mental health - we are lacking the communication to know when others are doing research that we also are doing
- We need to keep closer contact with the CHBs - good communication links with CHBs and PHC are necessary
- Government is fast-tracking everything, why was all structure removed before the fast-tracking began. What is so sacred about Oct 1st.?

Baddeck

- Hospital - Baddeck - very proud of hospital, community raised 20% of the cost
- Had cuts in beds and services here, looking back over we were still building new hospitals when we were cutting services
- Have an excellent board here

- Auditor General Report - quoted from, regarding Department of Health re boards
- Core services make or break any facility
- Need definite idea for community, regional, provincial
- Victoria County has 2 areas, geographic problems, relief staff missing, staff are overworked
- Why bring in staff for 4 hours when you pay them for 8
- What can we do to retain nurses, 3 nurses out of entire graduating class stayed in NS, casualisation is a problem
- Acute care beds in Buchanan Memorial were almost shut down this summer for vacations because they did not have enough staff to cover
- The problems are not confined to Neil's Harbour, also same problems for urban areas
- Another major problem is equipment, ambulance services have major problems due to the environment
- What services do we offer
- In Baddeck, we want to maintain the services we have, Buchanan is facing cuts of up to 33%
- 1 RN and 1 LPN to run the hospital (10 beds) (Neil's Harbour)
- We need adequate staffing
- Accreditation - cleanliness - Buchanan - 1 janitorial staff
- Blood in the toilet
- Floor washed but not sealed
- Having the facility is great but you also have to have the staff to run it
- We are facing 10% cut, if you go below a certain level of service you can't provide the service
- Janitor was told not to do overtime hours for free
- Buchanan has a number of grievances pending
- Baddeck has not had cuts but has lost by attrition
- an impact on Baddeck facility within the next few years
- I am against cross-training for health care providers
- Are you going to university too long or are we training staff too lightly
- X-ray staff, we are not having enough people
- Baddeck - OP load higher than Buchanan or Canso
- Lab - you can't just train another discipline to do the work
- Transportation is non-existent
- Three major issues identified
    - a - budget issue
    - b - training issues
    - c - volume issue

-$100,000 is a major impact on what is delivered south of Smokie
- Schedule B cuts
- Attrition cuts took place

- Staffing
- Budget issues, 10% is a major impact
- Aging population
- Service cuts are difficult in rural areas
- First Nations issue, 2 reserves

- Large area, 5 ambulances, down to 4 during the night
- Have severe staffing problem
- Very hard to get staff to come to rural areas
- 6 months low staff, supposed to have 8 people, only have 6
- Working 120 hours per week
- Department of Health looks at runs out of each area, Baddeck covers many areas and has high numbers
- Each call is 4 hours, 23 calls is a lot of time
- Geography - as you move further away from the TransCanada your time slows down
- Policies are set for the Halifax area and these are not necessarily transferable to the rural areas
- All season tires just don't work here
- Should have four-wheel drives in the area
- Winters are not as severe as they used to be

-Funded by Home Care Nova Scotia
- Have more staff than they have work for, due to geography
- Staff training is in Sydney
- Victoria County is the most expensive in the province due to lack of work
- Many people still live at home, with family members
- Sometimes just to put someone to bed the person has to travel many miles over dubious roads in a vehicle the worker has to provide and maintain
- Diabetes in FN is problem, off the FN we also have a problem
- Type II diabetes
- Diabetes education 2 days per month
- Education today had physician to talk about early screening for
- Prevention and promotion is necessary
- Rural needs are very different than urban
- Baddeck is in the middle of no where

- Satellite service from Baddeck has been cut due to lack of staff
- The FN community is left out
- The FN people don't come to Baddeck now because the workers from Baddeck don't come out any more

- Wants to support Joan the Dietician and Margie
- We are unable to provide the services we used to but we can no longer afford them
- We need to look at prevention
- Put more money into prevention, especially youth and children to teach healthy life styles
- Major problem, not just money but also human resources

- How will we have an impact on government?

- Will our report be made public?

- Public health nurse x 25 years
- Still calculates the number of immunizations with a pencil & paper

- We need to be able to offer isolation pay for North Victoria County in order to retain nurses
- Area with high rate of teenage births,
- The government has cut the staff in this rural area by 1/3 in the last 10 years
- Inverness County is also losing staff
- We don't have alternative support programmes in this area, the PH Nurse has to do this
- Having the PH nurse standing at a copier for hours on end takes the nurse away from the patient
- Spends about 40% of her time doing paperwork
- Goes into schools to teach healthy lifestyle and then the kids go to cafeteria and are fed high fat content meals after learning about healthy living
- The government needs to get its act together

- The CHB and the facility manager should get together to discuss this issue
- The people in Victoria County need to have the services provided here, if you cut lab & x-ray and have to send the blood to Sydney, you should send the patient to Sydney instead.
- CHBs unable to get information from the Department of Health and were threatened that it was not in their best interest to pursue this
- We now have more administration in the system than we had 6 years ago and we have had cuts in the system and deliverers
- It makes absolutely no sense to change the system from 4 RHBs to 9 DHAs, the cost is ridiculous
- Costs per bed is lower in rural facilities than in Sydney or Halifax

- Rural communities can provide a model of how to work together to provide primary care
- You don't see that cooperation in the larger centres
- RHBs to DHAs will lead to different ways of doing things, different unions etc, the system needs to look at how rural communities function

- Economic problems
- Rural area - aging population - declining student population
- How do we turn this around
- High unemployment, seasonal work, stress
- These won't improve here until the economy improves
- Tourism is not really working as a draw
- We are still losing our young people and the economy won't improve without the entire gradient of working ages
- Economic problems of Sydney, I am scared the governments won't listen to the representatives from outside the Sydney area, and the problems there will push our concerns into the wasteland

- Only Social Worker in County
- Volunteering is phenomenal
- We have very limited access to mental health services
- One social worker in school system that visits occasionally
- Very few places to turn when you have difficulties
- Addiction services are slim

- Paramedic in Baddeck
- We see trends at the sharp end of the sword
- Addiction services - the majority of the people I see don't need docs, nurses, police, they need addiction services
- We know by the address what to expect
- Seeing increases in children smoking and drinking
- We see many intra-facility transfers of elderly
- Long trips to take people to see specialists in Halifax or Sydney
- Have no one to call in the middle of the night for addiction services
- For everyone we transport we turn away 5 others because we know they are just drunk

- We have many wonderful volunteers in our communities
- We are increasingly using our volunteers
- There is a definite lack of coordination and training to provide the volunteer services

- Supervisor in long-term care facility
- Increasingly acute needs
- Lack of nursing staff
- Staff worked to their limits
- Funding from Department of Health does not provide for training
- We have to travel to Sydney or Halifax for education, which doubles or triples the cost of education

- RN at hospital
- Community still reeling from cuts of 5 years ago
- Nursing and technology shortage

- Staffing problem at hospital and tech can't come in, then the EHS has to transport the patient to Sydney, then all other trucks have to shuffle around to provide the coverage

Bear River

Points of Information brought forward:

- There is an issue with federal/provincial jurisdiction
- Native communities are not involved in the process of sorting this out at this point
- Differences in definition between acute care and chronic care: labels used by health professionals do not always fit payment definitions by provincial or federal bodies
- Native communities are not part of the district health authorities
- Holistic (they prefer spelling this with a "w" because it gives a greater sense of their understanding of wholeness), environmental health gets put on the back burner. They don't know what's in the fish they eat and everyone is reluctant to tell them
- For the Native Community, health is holistic: comprising mental, physical, spiritual and environmental – in a circle as depicted by the medicine wheel. No one element stands on its

own, they all go hand in hand. They can identify all of these elements specifically in their community
- They are also concerned about community members who live off the reserve. They want to be part of influencing the services available for them too

Responses to question "What for you is a healthy community?"

- Communications
- Equal access to up-to-date health care
- Health care comes to the patient, i.e., Home Care
- Catch-up with technology – health care providers need to listen to the patient and the community and need to change their paternalistic attitude (especially but not only doctors)
- Openness by decision-makers to different approaches to health care delivery (Minister of Health, etc.)
    - E.g. not always a prescription for drugs
    - Use models from other parts of the world
- A place to grow your garden and animals, with woods around you. Not closed in
- Living by traditional values:
    a. Proud of what you are, especially young people – history books changed to reflect that
    b. Respect for everything the creator has created: e.g., symbolic value of a rock or an artifact because its own nature and because of who it represents
    c. Spiritual - faith, respect body, take care of stress because it affects the spiritual
    d. Listen to the influence of grandfathers and grandmothers, both the living and those who are spirits. They may have more influence as a spirit than they did as a living being
    e. The grandmothers and grandfathers raise the children
    f. Note: jurisdiction problems affect respect for everything
    g. Example of respect for the environment that incorporates the whole medicine wheel: creation of the medicine trail by the medicine trail committee – in its creation the environment was respected in all ways, it gives people a chance to work with herbal medicines growing along the trail, it provides physical recreation and a chance to get in touch with the spiritual
- A community without disease
- A unified community
    - Pull together for common well-being
    - Respect each other
- People care for and about each other and are open to each other
- There is honesty

Responses to question: "What services do you need in your community to support and promote this kind of healthy community?"

- Provide home care for people on the reserve
- Deal with people who are going into nursing homes (both native and non-native) with dignity and respect and with consideration for the individual circumstances of the individual and their families, with respect to the giving over of all assets and income.
- They are often treated like second-class citizens

- All money is looked at and control taken away
- Individual needs and cultural situation is not taken into account
- Take direction from the grass-roots up, considering *the complete circle of health (medicine wheel)*
- Respite care - this often takes more time in rural areas because of transportation and travel difficulties. The ideal that services are based on numbers may not always work. If its good for one person, its important
- Bring back what was working before, e.g., delivery of normal newborns
- Emergency care:
    a.. Sufficient services that an older person has a sense that he or she will survive a crisis like a coronary
    b. Available for "all Nova Scotians" including those who live on reserves
    c. Needed to attract retired people to rural areas and have them stay – often they move to urban areas because they are afraid of being too far from health services
- There is a fear that if we continue to express concern we'll have a US style system with charges for everything
- Better management of the resources we have
- Fear we'll cut back so far, we'll have to turn around and replace. " What good is economic development if we don't have healthy people?"
- Fear reduction of services when business/communities are reduced and down-sized
- Scary that genetically-modified foods have been introduced widely without our knowledge
- Need better information on developments in areas that affect our health
- Better education and information and consultation before making major decisions that affect the world

- Enough mental health and psychiatric professionals and services
- Family violence
- Counselling
- Marriage counselling
- Better integration of work between government departments
- Concern that programs that are for "all Nova Scotians" are not for the Mi'kmaq who live on the reserves, that "we are Mi'kmaq *in* Nova Scotia, not *of* Nova Scotia."
- Lack of cultural appropriateness of services provided to native peoples
    - E.g., mental health and physician services
    - Culture training needed for all health professionals: mandatory initially, then regularly upgraded
- There is lack of First Nations/Mi'kmaq input in policy and program development, e.g., in health districts
- More information on what services are available to the general public
- Respect for the input/assessment of First Nations professionals
- Want to see clear impact on the native community as a result of involvement in groups like Community Health Boards
- Want to see ease of access to community home care nursing:
    - The definition of acute versus chronic can result in no care being available when badly needed

- The services is not "easily" available for First Nations people on the reserve – not eligible for provincial home care nursing - it is for all Nova Scotians but not natives
  - The federal allocation for home care is not sufficient when even one person needs the services daily
  - Need continuity in people and delivery
  - Program on reserve has a restriction to use RN's only
  - Lack of discharge planning for natives and non-natives

- A doctor leading a case conference was abrupt in his remarks, did not ask for the patient's decision and allowed for little dialogue
- There is now a federal initiative to combine "home care" and "adult care" (home support) so that less funding will be available for each
- Won't work: the band runs adult care so that it respects the culture and needs of the individual
- Need equitable home care for our people as Nova Scotians – home care for people who need
- Need for consistency of services and support between natives and non-natives who live in the same community: need to work together as a whole community using a holistic approach
- The priority should be the client or family and the service they need, not on where the money is coming from
- Access to primary care services in a small community. . . most resources and opportunities go to larger communities like Eskasoni

Comment: There are much better services now for follow-up after childbirth than there were 19 years ago. The Public Health nurses in Annapolis County were exemplary in working with this native community.

1. It is important to have specialized services in the province: it would be ideal if there were teams of specialists available as needed and as close to the community as possible, e.g., visiting specialists
2. Equality of access to the whole range of services that affect determinants of health
3. Need doctors who will stay here and not go to the States
4. Well Women's clinics in the (native) health centre are much appreciated and are expanding to other services
5. More allowance for sessional fees for doctors and not just fee for services
6. A way to deal with complaints and referrals re health professionals
   a. Need patient advocates in hospitals
   b. Need to have someone who will help me ask the right questions
   c. Health professionals who will walk the patient through all of the issues when you don't know what even to ask about
7. Need health professionals other than a doctor (e.g., nurse practitioner)

need doctors who have up-to-date knowledge

Bible Hill

- Brief overview of what association is doing
- Asking for support of PHC

- Re: continuum of long-term care for seniors
    - Under legislation:
    - Health Services Act
- Community based options
- Many options exist with care for people without legislation of licensing or regulations - market driven
- Recognize and legitimize these homes, ad hoc committee formed - owners of some homes, family members, seniors, clergy, medical people, resource people, Department of Health and Department of Community Services
- Formulated draft regulations
- Finished the model (not intended to replace but to supplement existing options)
- Ministers Action Committee on health care reform
    - Long-term care facility should be rationalized and ensure provision of care as close to home as possible
- Delivered to Minister of Health a set of draft regulations and propose a pilot project to test this model
- Provide single entry options for a variety of placements
- Is personal care home a reasonable alternative
- To allow seniors to make their own choices
- To prevent early placement
- Haven't heard back from government yet
- Copy for council - if we see fit - supply support for our endeavour
- Allow seniors to choose where they want to live
- Ensure a consistent level of service in these homes (about 50 in Colchester County alone)
- Some are providing excellent care (personal knowledge), wants to ensure that the others have equal level of care
- Bring the service to the senior, don't take the senior to the service
- Look at HCNS providing support to enable the seniors to stay in these options
- Look at the cost - some personal care homes are $60 per day, Nova Scotia $100 per day in nursing homes
- When their money is exhausted, they are moved to nursing home
- Was presented to Dr. Smith with the former government
- From the audience - the homes are paying taxes, Workers' Compensation Board, no breaks on groceries or drugs. They are definitely known about
- Transportation
- With great aunt 80 something, never married, lives alone, transportation a problem

- North Shore
- Transportation a problem
- There is a bus but not terribly convenient
- Winter makes it worse
- A lot of elderly without cars

- Concerned about retaining the services they have in their areas
- Extremely critical because of transportation problems
- Message has to be plain and simple

- There are too many pieces of paper
- To deliver services - put people who know how to do out there where the consumers/users are
- Clear out the theoreticians and bureaucrats
- We need health workers who can do counseling, more personal care workers
- Address prevention/promotion
- Nutrition talks - practical
- Mothers talking to mothers about babies
- Needs to be organized in some way
- Let's just get at it
- We know who needs help in their community - get on with it
- We don't need glitzy and complicated
- We need the comfort of other human beings helping one another
- We have HCNS in our area
- We need assistance in mental health issues
- If only we still had someone like the public health nurse
- We need school nurses, school councilors, people who will be able to deal with issues as they arise daily
- We could cut down on a large number of emergency room visits and doctor's office visits if we had someone to talk to in the schools and the community

- Truro has a critical shortage of doctors
- Not a problem in North Shore
- North Shore needs more front line workers right out there doing the work, not more doctors

- Transportation
- Announced last week
- A van traveling once a month
- Long waiting list (wife has back problem)
- 3 kids - one in co-op program
    - Daughter is nutritionist (needs to do internship)
    - Only VG takes 8 a year
- Hospitals should look at co-op students from the schools, can provide the work for little money, get job experience
- Computer science students are widely taken for co-op programs
- Was one nutritionist placed at Ryan's IGA here

- Teen health - teaches at CEC
- Large rural population
- Many unable to get to doctor
- School recognized the problem
- Setting up teen health centre in the school - looking at Red Door, Kentville and J.L. Illsley School in Spryfield

- Retired nurse
- Seniors advocate

- Chief complaint - Jamie Muir says we have enough doctors in Truro - unable to get one on phone
- Schools without windows, too much cement, sick kids
- Not enough breaks, 6:40 a.m.
- Kids are too sleepy and tired
- Travel money for people with disability ($18 per month)
- Bringing people in from outside and paying extra large salaries and our own people are starving
- Upset with people on social assistance who need $80 puffers for their asthma and still buy cigarettes while the taxpayer pays for the puffer
- On very small pension - we don't recognize nurses' service in other provinces
- Nurses, phone men, power men on roads not fit to drive on are worth more than the deputy minister at $180,000
- All departments need to help out the situation
- Work with student nurses - 8 students is maximum for co-op placements. But we need to build more capacity
- Junk food in school is a problem

- Rural areas
- Some services we never get
- Had some better services 25 years ago, e.g., mental health
- Crying need for both our adults and our children
- Mentioned community centre
- Need debt counseling
- Need respite care, adult day care
- Working with seniors forum to look at this
- Eternal problems of long, long waits for diagnostic work up
- We have a paranoia - we saw what happened in our area and Pugwash area where hospital downsized to 2 beds with short stay
- We still do have 24 hour lab, the only one on the north shore (Tatamagouche)
- Worried about losing the service they still have
- Roads bad during winter
- Single entry point
- Need to be more open in what is available to the people
- Rural area residents resent being inquired about their finances
- If you are prepared to pay your own way they shouldn't be able to pry into your
- Prices of drugs are out of this world
- Doctors are charging like crazy for all non-insured service
- Social services recipients can get 3 months supply
- Doctors in Truro are not taking new patients

- Small options owner

- Colchester Hospital
    - Terrible place

- Don't give us expensive DHA's offices with lots of theory people, we need front line people

- Cut down on the expensive printing
- Cut down on administration

- Emergency home care
- You can't send someone home ill and not admit them if there are no beds
- You can't go to hospital unless you are dead or dying
- Discharged too soon
- Re-admissions are up
- Colchester Hospital is terrible
- Acuity is getting worse

- Bass River - well serviced. Two doctors who won't make house calls. Both from away
- Clinic in Bass River

- In Truro - true doctors still make house calls

- We need more nurses
- Nurses are overworked
- Nurses are supplying good service

- New products:
    - allergic to ____
    - Cause random effects that doctors don't know about
    - Doctors don't get educated well

- Problem health care system needs to get ready for:
    - Too much information out there now
    - We can't get it all together

- Child health centres like they have in Australia, England
- Nursing station where child checked within 1-3 weeks, weighed, etc.
- Could be handled by nurse - don't need doctor for this stuff
- Nursing clinics - doctors wouldn't like it
- Rural communities are very self-sufficient and want to deliver the care in their own areas, close to home
- Antipathy and resentment about the health care system
- Why did they take away the previous hospital boards - all volunteers
- On site managers

- Communities are upset that Colchester Hospital took their money and don't provide the service
- Tell the Department of Health to cut out the taxes on funerals ($1,000 in taxes is too high)

Bridgetown

- 1994 - Halifax announced changes
  - Board supports a community needs assessment
  - Used to set up various projects
- 1997 - All of community health plans for Annapolis County plan done and is available

- 1997 - Established 24 hour emergency
- 1998 - Set up with 4 beds
  - Transport care
  - Primary prevention and promotion clinics set up
  - Ophthalmological clinic and service
  - Ambulatory clinics - medical, surgical, OB, pediatrics, gynecology, mental health
  - Reasonable accessible primary care project
  - Treatment in Annapolis means 1 less on gurney elsewhere
  - See demographics in Community Health Board plan
  - Greatest need for communication
  - Need to provide basic services in the community and keep people informed about what is available
  - Accreditation Survey of 1999 says service very good
  - Soldiers Memorial Hospital and Valley Regional Hospital provide secondary backup to Annapolis General Health Centre

- Currently provides respite care

- Workbook - ambiguous, leading, useless
  - Disregard all input from books

- Physician recruitment
- Wife and self both Newfoundland family physicians
- Originally from here
- Came due to recruitment process in Bridgetown
- The process is effective but is not as effective as it could be
- More came because of community efforts to locate in Middleton and Bridgetown. The communities made it very attractive to relocate here
- Need to pay more attention to recruitment and retention
- Bridgetown has seen 8-10 physicians come and go over the last 10 years
- The Department of Health program needs a thorough review and needs to become more proactive in recruitment and needs to work on incentives to retain services of doctors
- Volunteered to work with the Department of Health on that program

- Need stability in the system to help with recruitment and retention
- We need to impress on government that just because they have another idea it is not necessarily good
- Look at what is here and working and retain it

- Instability is major reason for losing doctors

- Annapolis put together a package to recruit 2 doctors
- Government needs to get out of Halifax to see what is out here and what works - rural life style is different from a city life style
- Will we have to do it again in 2 years

- Need to maintain the hospital to keep the doctors here

- We desperately need the seamless health care system
- They land on her doorstep to ask where to go and what to do
- Need to have integration of information systems
- Don't re-invent the wheel
- The Western Regional Health Board was at the forefront of regional development
- Don't lose what we do well
- Move gradually to DHA - don't lose what works well

- Pharmacy is wired but not inter connected with other pharmacies. They are with MSI and third party payer but not with each other

- Need seamlessness and a good home assessment

- If it ain't broke don't fix it
- Lived in Annapolis County 2.5 years
- Before that, she lived in Shelburne County 4 years
- Western Regional Health Board - good, valid ways of operating
- Annapolis County did good work
- Will SRAC continue?
- Concerned about workbook - no directions given in differentiating between the community, regional and provincial levels
- Evaluation form - totally unusable - blocks don't line up
- Green part - she's been a nurse over 30 years and knows that but general public won't be able to use

- Private dietary counselor
- Also works in nursing homes
- He runs a healthy cooking programs in community
- Over 300 dieticians in Nova Scotia - most often primary care
- Provision of dietary services at individual level is most important
    - Are available for specific disease entities
    - Individuals in community are not able to access out their community health centres or hospitals and have to access private service and pay for it

Recommendations from A:

1. As indirect financial support Department of Health consider encouraging private payers to support payment for private dietician counseling. Life style/recreation/nutrition

2. Through referral process by doctor an individual could be sent to a private counselor (not necessarily associated with CHC or hospital) - they are provincially certified - level of care/intervention should be there. The service should be paid for through MSI service

B. Support of funding to group programs through such programs as Community Health Support Funds.

> Problem - funding is seriously restricted so programs have to be downscaled, not able to carry out evaluation processes to prove these are useful and should be funded.

- One criteria is usually that they be self-sustaining

- Recommendations:

1. Encourage government to increase level of funding to these programs so they can provide a more enhanced program than is currently possible

2. Fund repeat programs to allow building on previous work (1 time doesn't work, it often needs 3 to 4 sessions to make a difference)

- With Heart Health previously
- Workbook set up a possibility that we might have the services in all communities
- A better question would be "what would make it easier to access the service"
- Transportation - put more money into infrastructure to help people access the services
- During times of cuts - downsizing happened but support at home didn't happen
- If you downsize - put supports in place first
- Community volunteers are saving incredible amounts of money with no recognition/tax breaks, etc. for community volunteers
- Education - class sizes are increasing. Leading to more stress on teachers - need supports with schools, and with home. Need to teach healthy life styles and support the parents

- Annapolis General Hospital - previous input to PHC with Mary Jane Hampton and no one heard anything back
- Need to communicate to the people what is there and how to access it
- Needs to be feedback
- Ensure there is response back following this exercise

- Volunteers - need feedback
- Was with Community Health Board
- Is this just an exercise to make it look good

- We need to keep community control with the support of the Department of Health

- Questions

- Don't cut/cut/cut - governments lose because of this

- Nurse practitioners need to be utilized
- Could be used in out patients department
- Doctors don't like to walk in out patients department but wants to make money
- Nurse practitioners used in north
- Pathologists
    - 85% work on surgical specialties $150K
    - Could do more to teach and support general practitioners
    - Western Regional Health Board - guidelines - not approved
    - Conflict re: structure of pathology services
- Life styles
    - RCMP/senior citizens visits
    - Dieticians could do the same things
    - Valley is an area of good Christian values here
    - Visit groups
    - Roads are too narrow
    - Life styles education needs to be in schools

- People don't know anything about magnetic therapy

- Day to day routine with doctors
    - As fast as can so they can go back to office
    - Poor communicators
    - Need less contact between doctors and nurses

- Concerned about nurses
- If we don't have numbers we will be in big trouble
- Nurses are leaving Nova Scotia
- Concerned about doctors and nurses

- We talk about wellness, care givers, etc.
- Concerned about sick patients but they are discharged too soon from larger centres
- Same day surgery should be known as half day surgery - turn up as sick
- Need nursing home beds
- Need home care support
- 4 short stay beds
- Need convalescent care, restorative care
- Need okay to open more beds in Annapolis General Hospital
- Home care and ambulances didn't work. We need to go back to what we had

- Retired nurse with specialization in gerontology
- In 1994 - no jobs available
- Number of nurses coming along is too small
- BN's not ready to go to work when they graduate
- Desperately need nurses - and nurse practitioners

- Home care doesn't work
- There is not enough of it
- Not enough time for the patient
- Co-ordination is poor
- Not enough time to do what needs to be done
- Care givers aren't working well

- Experiment re: sharps containers
- Decreased hospital stay - movement to community
- Increasing hospital waste now in the community as a result of this
- Are there any plans for recycling the medical waste?
- This issue was on CBC radio
- Needs to address this issue
- Recyclers need a safe environment too
- Diabetic Association was concerned about this issue
- Need to look at this issue

- Concerned about quality health care
- Professionals are excellent
- They are overworked
- Not enough people in each profession, not enough variety of professions

- The nurses are making the system work
- But they are burning out

- Representation on DHA's needs to be fair!

- Volunteers need to be recognized

Bridgewater

Recommendations:

- Needs to travel to Halifax 3 days a week for dialysis
- Treatment in Halifax is very good - the problem is not with the treatment in Halifax. It is with the need to access transportation to get to Halifax
- 2 here are at least 5 others in the area who also need to go to Halifax as well
- Keeps him alive - has expressed his appreciation to doctors and nurses for all they have done for him

- Looking for alternative transportation mechanisms
- Should not be the responsibility of family or others to provide transportation
- Options: Transportation system to/from people with trained people in the vehicle (assume responsibility)
- Dialysis centre in Lunenburg County. Sydney, Halifax and Yarmouth only places which provide central line dialysis
- "Should my wife be responsible for transporting me to Halifax 3 days a week for this treatment which is required to keep me alive"

- Core services already identified by Western Region
- Make sure we have a copy
- Savings rewarded locally
- Importance of seeing the whole when making decisions on individual parts
- Public input is important
- PHC offers an arms length opportunity - objective advice
- Aware there are several ways that information is being surveyed
- Core services review in Western Region - 14 months ago. Synopsis of what the core services would require:
    - Allowed for professionals within the regions to be involved in discussions. What we have begun needs to be integrated into the emerging DHA structure
    - No reward for fiscal success of merging of Fishermen's Memorial Hospital/HSA
- Need to be careful that services are available closer to family and friends, versus all
- Statistics re: 75 years old/65 years old - indicating an issue with the elderly population in the area, all of which will require additional health care money in the future
- Don't want to succeed at the expense of other areas - removal of one part of the system can create a domino effect right through the system. Need to consider the ripple effect of one decision within a core service and its effects throughout the system
- Have to consider the importance of health care professionals and volunteers (75-80% provided by family/friends/volunteer supports)
- Promotion and prevention is important - requires new financial

- Community based hospitals built before government began to provide funding for such institutions. Felt distanced from the Western Regional Health Board - they were just too far away
- Recommendations:
    - Retention of core hospital services is essential (i.e., Fishermen's Memorial Hospital). Two essential services - 24 hour outpatient and emergency services, lab, x-ray, 2 special, 15 acute care beds
    - Extreme volumes of traffic exist (500,000 visitors to Lunenburg, especially due to UNESCO World Heritage Site). Those visiting tend to be primarily seniors
    - The inequity of 2.1 beds per 1,000 needs to be addressed
    - A mechanism for ensuring community input in the use of local fundraising contributions must be established. The community was so frustrated that they were being denied opportunities to use money - i.e., CAT scan. Want to ensure there is a means for money from trust to be used the way the community decides
    - Bone densitometry unit is an achievement of Fishermen's Memorial Hospital (many people come to use the service). This and other initiatives is based on a philosophy of

"striving for excellence." Trying to look at seniors issues - community health boards identified this area in their community health board plans. Veterans Affairs unit is another example of working with seniors and striving for excellence. Want the opportunity to preserve the ideals that Fishermen's Memorial Hospital was originally built on for now and into the future

- Brain injury should be recognized as a separate and distinct disability. Brain injury is the number one killer and disabler of Canadians under the age of 44. Change the disability classification to include brain injury (this is the norm in most other Canadian provinces

- The continuum of care for brain injury survivors needs to be clearly defined.
  Gaps - rehabilitation programs. There are a limited number of beds
  The provision of 14 long-term care beds in the rehabilitation centre in Waterville has been stalled by bureaucratic red tape by the Western Regional Health Board

- Community support centres for the brain injured are needed in each county
  - Need for separate category (identification) and special rehabilitation geared to brain injuries
  - Some projects underway
  - Centres in each county
  - Club houses - self-esteem, socialization

- Need to maintain mental health services at a community level
- Need a continuum of mental health programs - from health promotion to hospital stays, need to be maintained and in an individual's own community
- Mental health program is small - in terms of dollars. Adolescent beds are difficult to access. Housing is very deficient in the area. Employment opportunities and transportation are problem. Mechanisms are in place to provide back up consultation - but they don't know where the money goes
- Global need for mental health wellness and mental health promotion. Have made some inroads with the region - what will be the effect of more fragmented programs. Small voice in a larger organization - can't be heard when time is constantly spent fighting for money. Hard to get psychiatrists and other professionals
- Concerns - front line people. Talk about health promotion - and we need to remember that the front line people are the ones who need health promotion
- Please stop the chaos - to get our house back in order, need a long-term plan that is not dependent on every political whim and is based on a long-term fiscal plan
- Seamless
- Equity - money and access to specialty services
- Close to home
- Housing: group homes
- Transportation
- Community involvement in decision making, e.g., money

- Same system but under a new guise. John Hamm did not build in public consultations. The information for the workbook has already been done in the Western Region (and even before regionalization 4-5 years ago - Dr. Sundin has a copy of this document in his office)
- Critical mass needed to function as a full core regional hospital - Lunenburg/Queens have a population barely large enough to function as a full staffed regional hospital. Most acute care specialists need enough work to attract and retain physicians. What were barriers to people coming were too frequent "on call" and total vacation coverage. Many small community hospitals are too small (24 hour emergency care [in small care facilities]) to operate as fully functional hospitals - medicine is not the same today as it was when those hospitals were built
- Decision making process - when regionalization came about it became a decision making disaster. 12-18 months to make a decision, and sometimes an answer was never received
- Could be a danger that it will happen again - and the DHA's will be 2/3 community health board appointments and ½ political appointment (by minister)
- No physician in any decision making capacity in the region
- No guarantee those in a DHA will have any knowledge of acute care
- Fiscal restraint - "emphasis should be on health education and health promotion and redirected from existing systems. Concerns from doctor as there is no money to be taken from acute care. Too much has already been taken from this system. Health promotion is very expensive and not very effective (for every $1.00 put in you get $0.25 back)
- We don't need any more acute care beds in Lunenburg County - but need to ensure those who need to be long-term care facilities should be so the acute care beds are used
- Where money can be obtained is in the administrative system at all levels. The Department of Health in ____ need to be looked at for administrative money savings
- Need for meaningful public input
- Core services for regional hospitals
- Regional hospital in Bridgewater
- Critical mass needed (60,000)
- Recruitment difficult
- Also need critical mass for community hospitals
- "Regionalization was decision making disaster"
- No guarantee of hospital representatives on district health boards
- Emphasis on health promotion and education. Can't keep up hospitals
- System is over-administered

- HSA - asthma care centre representative - operating out of Fishermen's Memorial Hospital
- Asthma - second only to PEI in Nova Scotia
- Asthma education has been identified as a critical component (assessment, education and on-going follow up)
- Seen over 700 clients (plus those who accompany them and play a role in the management of the asthma treatment)
- Shared the process at the asthma care centre - what a client would be involved in or do. Initial assessment and a re-assessment process
- Have had measurable results - dramatic decrease in hospital admissions, decreased emergency room visits. Translates into a great deal of money saved. Things no so easily measured are absenteeism from work, school - and an improvement of an individual's quality of life. "Asthma under control" happens at all ages

- Take serious note of what the asthma care centre can do - want to maintain the service as it exists and would like to do even more into this area
- Education essential to control
- Whole group involved in control
- Clients followed as needed
- Proven effectiveness, ___- measurable results in reduction of care needed

- Hospital beds - problem with chronic care beds, patient occupying hospital beds. Important. Need for appropriate placement of patients in

- Decision making (slow)
    - Community health board members different from district health authority member

- Include physicians in decision groups. Community health board members will be DHA members - this is a significant amount of duplication. Assumption that community health board members will sit on DHA's. People who know health but are physicians - and they should be included in the decision making process. Won't serve the decision makers well

- Geriatric assessment clinic - partnership. Contribute to the ability of keeping seniors safely in their home. Two a month with 2 consulting physicians (from Geriatric Clinic). There is an interdisciplinary team working in this area - 75-85 years is the primary age seen. 155 clients in 1999 (26% increase, 10-25 clinics in past 2 years). There is a 3-month waiting list - in Lunenburg County, 7,800 ages 65 years or older (19%). Queens County would further increase the number
- Formed by hospitals, long-term care and home care
- Includes assessment clinics
- Large increases in people seen and clinics held

- Explanation of palliative care - services are sadly lacking
- Services available lack a co-ordinated approach. The Department of Health recognized many of these issues - Oct. 1997 looked at how to integrate palliative care in 1997/98. Document called "Integrating Palliative Care in Nova Scotia" - much review and discussion. Defeat of government (Liberals) led to loss of allocated funds for palliative care. Thought this time, co-ordinators in region - took a co-ordinated approach to sharing what palliative care could look like in the Western Region.
- 11 focus groups in 2 ½ months. Various care settings, people from different disciplines - support both regional and provincial document
- Palliative care needs to be a core clinical service in Nova Scotia
- Support for respite, supplies, cost for drugs, co-ordinated approach to care (VON, home care, home support agencies)
- "Broad brush" education - need to know more about palliative care
- Copy of the regional document - needs to be a core service in the province
- Lacking services, co-ordinated approach
- Core, essential service
    - Home
    - Co-ordinated approach

    - Education and information needed
    - Need for formally trained physicians and nurses

- Oral health - this area has been overlooked - don't provide oral health services to adults, disadvantaged youth and others. Dental hygienists are an important part of this health. Education is a key factor in preventing oral disease - and is something that can be done by dental hygienists
- Small number of dental hygienists in public health - education, assessment of school programs, flouride mouth rinse, and some preschool education
- Barriers to accessing oral health care:
    - Geographical issues
    - Education of parents
    - Transportation
    - Fear or anxiety
- In other provinces dental hygienists provide oral health care - improves access to care in remote areas and those who are homebound
- Restrictions in Nova Scotia legislation restricts direct access - with special written permission from Dental Board, dental health can work on client within long-term care but certain restrictions apply
- Dental hygiene services are accessed without a dentist. New legislation that would allow public direct access to dental hygienists. Would improve oral health. Increased attention should be given to using dental hygienists in many places - new model of oral health care delivery in the province of Nova Scotia
- Importance to overall health
- Only 25% of children (eligible) access health services
- Hygienists full practice are restricted by legislation

- Fiscal restraint - budget has increased over 50% over past few years. Who is benefiting from this increase?
- Mental health budget - 40% of province lives in Halifax/Dartmouth but 60% of budget goes to Halifax/Dartmouth - deserve more money in our area
- Part of the problem is QEII - 6,000 employees. We are subsidizing Halifax/Dartmouth - as they are going to run a deficit. What can be provided locally should be provided locally
- Ambulance service - ridiculous that people to pay for an ambulance to Halifax is a tax on rural living
- Doctors are experts on illness - not the experts on health. Governments need to develop a long-term, multi-faceted approach to health (all government needs to be involved). Need a plan that's not going to change after each election - because of this lack of direction, volunteers are feeling burned out by the process and need to be nurtured
- $1.2 billion - $1.8 billion
- Major problem is QEII
- Health not controlled by Department of Health
- Volunteers becoming burnt out

- The restructuring has led to 5 different employers - the staff has had to undergo a significant amount of turmoil. For the core services - need to be staff; need to feel that when they come to

work that their job is NOT on the line. Everyone is working so hard - "I wonder and I worry about what will happen with the next budget"
- Need staff who feel they're in a stable situation

- Proud of densitometer - like to be offered throughout the province
- 2 week waiting period - 7 month waiting period in Halifax. This service can be made available to others across the province

- Where to go from here:

- Report by March 16 - indicating what Nova Scotians have indicated at community, cluster of communities, provincial
- May 15 - paper for cabinet on core health services (broader)

- People who spoke this evening aren't representative of those people who use the system. More indicative of health providers

- Money's there - it's not being spent properly
- Alternative treatments like healing touch important
-

St. Peter's School
Dartmouth

- Went to 2 out of 3 community health board meetings
- Loneliness/isolation leading to depression with elderly
- Suggested opening a centre at Alderney Gate (near ferry) - central place - easy access, have it all together - library there, need 1 comfortable room for different groups to meet, e.g., bereavement/emotions anonymous/addictions/survivors of elder abuse, (emotional/financial) (need to deal with shame, etc.)
- Need a group like Alcoholics Anonymous or Gamblers Anonymous - need a bit of financial support
- Groups for teenagers, social group, e.g., birthday sessions, have central place with social services present, accessible, low cost
- Self-help groups ensure confidentiality, increased self-esteem, need support post discharge, wouldn't cost a lot
- People coming out of the closet re: elder abuses
- Increased social activity leading to increased self-esteem
- Could have social worker from Community Services to provide support
- People are living longer leading to placement long-term care - these people have saved for years - but now have to pay a lot of money
- Removal of all money removes sense of independence - no money available for travel or choices

- Need all dental communities in Nova Scotia need to receive PHC information

- Children from low income families need to know where to go for referral for nutrition information, etc.
- Approximately 600 dentists in Nova Scotia

- Canada - provides the service free to low income who don't pay tax
- Middle and high income people pay taxes and then have to pay for services as well for home care workers

- Health care system is very poor, needs improvement
- Need stepping stone from hospital to home
- People are coming home too sick and need a lot of support from families who may not know what they are doing

- Follow-up on previous speaker
- Health care workers are sick so they can't visit her friend for 3 weeks
- Friend is alone and has no one

- Issues facing nurses
- Licensed practical nurses
- Shortage of nurses
- Casualization
- Precarious work situations
- Nurses at burn out level and are leaving Nova Scotia
- Remaining are burnt out

Suggest:

- LPN can and should play crucial role in health care system
- Allow respective skill sets to be used
- LPN's benefit from RN teaching in their program
- RN's need to be reinforced as managers, educators
- PHC needs to speak to rank and file RN's
- LPN's bring competencies to system
- Canada - LPN's not being utilized well
- Need to break down the barriers
- Approximately 3,200 LPN's in Nova Scotia
- Legislated regulation of LPN's through LPN Association
- All facets through LPNANS as with RNANS are self-regulating, etc.

LPN professional standards no longer spells out the scope of practice but does identify competencies and scope of practice

- The workplace - defines these through policy and procedure
- The workplace is now replacing task lists with competencies
- LPN's are allowed to do those skills (meds, IV monitor, catheter) in long-term care but not in hospitals
- System is giving family members greater responsibility for technical care that LPN's are not being permitted to do in system

- Nova Scotia/Canada - LPN/RN working together to identify and review issues such as recruitment/retention/educational
- More LPN's working than ever before
- Change ratios
- Long-term care 1:1
Acute care 6:1
Chronic care 9:1 Move acute care to 3/1 - it is cheaper care and frees RN to do the skill sets without requiring RN competencies
- Need system where all abilities of all practitioners are approximately utilized

- 3 things:
  - Health promotion at community level
  - Community partnering is essential (duplication shouldn't happen)
  - Department of Health current commitment to support ____ patients is insufficient. Need to increase low income cut-off

- Need network of community health centres around province
- Need 1 for each community health board
- They would provide place for self-help groups
- Health promotion
- Referral services
- One stop shopping
- Doctors and nurses should be on salary at these centres
- Support for her breast feeding moms
- Need Alzheimer support group
- Need 1 place and "separate from hospital where medical things happen" - so community things are under local community control (through community health boards, etc.)

- There is a shortage of beds
- No support in community

- Duty clinic
- Constraints from the system
- Provide service for 11 hours (doctors on 4 hours - see 40 people or more)
- Week-end coverage shows everything up
- Negation of acuity of people we are seeing
- RN does triage
- Funded through MSI
- Doctors control purse strings - RN employed in this clinic makes less than LPN's (not sure public knows)
- Government needs to support nursing profession with adequate pay and improving the range of service
- Role of nurse is not recognized here as it is in other provinces
- She worked as public health nurse in Newfoundland - from that she knows need to have longer visits - more cost effective for RN to do this than have doctors move through every 6 minutes
- Need good nursing follow-up for physicians visits

- Public health nurse has manned a breast feeding hotline for 20 years as volunteers
- Workers have concern about who would stand behind you if you give advice

- Identified need to educate the educators in medical school and nursing schools
- Doctors are triple booking and pushing stuff off onto lesser trained people
- Community people don't feel secure with system as it exists
- Young moms in metro are alone often
- Third time at information gathering sessions - what happened to the information before - will we ever see the results - or are we just repeating ourselves for nothing - the people are waiting to hear results - last 3 years have been information collection

- Need to use the information and resources we already have
- RN's and LPN's are not being remunerated and used appropriately

- Doctors don't make house calls
- They don't have the time

- New on community health board
- Critical need of health care
- Several themes that need to be followed up on
    - Recognize people already skilled
    - Continue upgrading and retraining
    - Provide protection for them as they do job
- As layman/citizen
    - Many inefficiencies
    - Hospitals shut down Friday to Monday
    - Home care option has great potential but not well developed and used
    - Need to look at long-term care - bed blockers are inefficient and wasteful
    - Need to have community essence
    - Horror story - wonderful cure
        - versus waiting for diagnosis or treatment
    - Will eventually - to 2-tiered system

- Discharges from hospitals are so acutely ill
- Many cases need 2 people at home
- We are expecting family to take over many of the tasks we used to do in hospitals
- This is a complex issue
- Home care services may need more than 1 person

(- May be no family)

- Need to deal with realities
    - Need to have cost effective use of tax dollars
    - Situation now is not what we had
    - Have decreased resources
    - Increased need for volunteers
    - Decreased funding

- 15% cut - $255 million
- What are we going to do
- Will home care be improved as an option
- Open heart surgery - 5 days in hospital

- We have learned to expect services we don't really need
- Need to cut from the top as well
- Shaw Report/Goldbloom Report/PHC - don't come cheap to do study - why are we still doing this
- We need to give a few hours in our communities to provide community infrastructure

- Turf protection
- Change has to take place at the top
- Need more services outside metro area

- The common citizen has to stand up and say enough - to the government
- There needs to be more equitable distribution of health care services

- What is the government going to do about promoting wellness
- That needs more emphasis

- Need exercise easily accessible and affordable

- From Eastern Passage
- Dartmouth has The Lakes
- Lake Echo has beautiful parks
- We don't make our horse drink
- Findley Centre - beautiful facility is underutilized
- We have a lot
- Think about wellness
    - Think about what we have and don't utilize

- Loneliness is a problem

- Nurse educator
- Also need education of general public
- Especially related to how do we access services and information
- How do we get to the poor and disadvantaged

North End Community Centre
Dartmouth

Responses to "What does it mean to you to be healthy?"

- To be able to not have to take my puffer, not have an episode of asthma in a day
- To feel useful
- Not to be in pain, hungry, cold, alone, worried about tomorrow
- To feel safe, to walk down the street without worry, to exercise outdoors without worry
- Absence of disease
- Good schools
- A roof over my head and a happy family
- Friends to socialize with
- To be mentally healthy, deal with stress, have supports available to deal with stress
- Access to health services when you need them
- Access to information like nutrition, diabetes, etc. at a level lower than the doctor
- A secure health system: to know that when I go back to my doctor this year I will still have access to the same services I had access to last year
- A place to exercise
- Clean water and food
- To be physically active to whatever level that I can
- A clean environment

Responses to "What does a healthy community mean to you?"

- One that promotes physical, mental and spiritual well-being of its people
- Good public transportation
- More smoke-free buildings
- Facilities to address need:
    - Environment
    - Exercise
    - Recreation
    - Food as needed
- Where people want to work together
- Where you are not scared to talk to your neighbour
- More fellowship
- A place where health concerns can be taken care of in a timely manner
- Consumer or client-focused in everything it has
- Has a central point that sees to it that services happen, a place where you can ask:
    - Information clearing house
    - Service coordination
    - Make sure the focus is in the right place and things that need to be done are done
- A clear vision and the courage to make it happen, that has a future:
    - Achievable
    - Articulated in laymen's terms

- Neighbours who help each other
    - Neighbourhood Watch
    - Boys & Girls Clubs
    - Support groups
- A positive attitude leads to healthy living at all levels
- This community needs a community centre (as partially described above)
- A Food Bank (one person said that they objected to the idea of a food bank because it meant that people in the community did not have enough food – there should instead be processes whereby each person has enough food, with dignity)
- Provide productive employment
- Education around healthy eating, lifestyles
- Lifelong learning opportunities and environment
- A safe place
- Responsible government at all levels
- Healthy public policy – an approach that looks out for how any policy or change will impact on the health of the citizens
- Enough physicians so that each person can have a family physician – many now can't get one as the current physicians will not take any more patients

Core Services Needed to promote, support and maintain the kind of health described above

At this point some felt that the first part of the exercise where we talked about what make for healthy people and a healthy community did not directly relate to what core health services should be available at each of the three levels (community, cluster of communities, province)

Community

- Subsidized day care
- A 24 hour walk-in clinic (perhaps not staffed by physicians all 24 hours, but with physicians on call for 24 hours and other levels of health care staff in attendance)
- A government kiosk available
- Services that are already there be more accessible: more information around about them, more easy to get to during times when needed
- Literacy
- Some place to get information and help
- Services for when I'm sick
- Access to a family doctor if you're not attached to a clinic
    - Not enough [primary care] doctors for the population
- Better utilization of human resources
    - More use of LPNs, technicians, Nurse Practitioners, etc.
- Emergency services including ambulance services
- Lab sample taking location, x-ray (broken bones, etc.)
- Illness screening services available locally such as mobile (accessible) mammogram service – an example was given of a mobile mammogram unit for which the steps were impossibly high
- Small community health centre
    - 24 hours

  - Information
  - Other levels of providers than doctors
- Social services/community services
- Child/parenting support and education
- Referral services to specialists
- Mental health

Cluster of Communities, District, Region

- A community or district hospital
- Emergency services
- A network of community health centres to work together to coordinate and integrate services
- Clear planning for community health centres to determine "market reach" and other variables

Province

- Establish some continuity: stop this: "starting.... stopping....starting..." which leads to constant relearning of things that were learned long ago
- Better (more realistic) allocation of funds
- Do some good research: determine what people in Nova Scotia are dying of, then plan and allocate resources accordingly. Determine the real health risks and focus on them (sometimes prioritizing issues comes head-to-head with politics
- Improve information systems to collect and review information and plan effectively
- The health system needs to be balanced: helping to improve and maintain health, as well as looking after me when I'm sick
- Also screening to help me to prevent disease and stay well – more accessible
- Access to community/district hospital and specialists should be more timely (told story of 4 ½ hour wait while having an asthma attack)
- Take politics out of the delivery of health services
- Volunteers would rather devote time to something that produces clear results
- Government has not listened in the past
- There needs to be coordination between departments

North End Community Centre
Dartmouth

- On assistance. Not enough money (can't eat healthy) in food allowance for food generally and especially for things like lactose-free foods
  - Non-prescribed materials have $49 deductible
  - Need to raise allowable earnings before benefits reduced. $100 a month is limit. Suggest indexed to current minimum wage

- Need a triage system in Dartmouth General Hospital for emergency 24 hour clinic or after hours clinic would also help

Wait 4 ½ hours, when you can't breathe nothing else matters. Need expansion of emergency

- Brain injury needs to be recognized as a distinct and separate disability. 1,200 people in Nova Scotia with brain injuries. Continuum of care for brain injureds. Traumatic brain injuries should be defined clearly. Responsible for majority of deaths under 44. Community support centres for persons with traumatic brain injuries in each community
- Source of volunteers for community action

- Chapter on social justice in recommendations
- Difficulties of living on less than $12,000 a year

Eskasoni

- Only 3% over 65
- Large population, the young, that need health education, especially emotional, mental and spiritual well being
- Much treatment is based on the current system, treating the illness rather than the whole individual
- We are responsible for our own health, not the docs, the shrinks, or the government
- Need to look at a holistic approach rather than the present medical model
- Need to promote the well being
- Emphasis should be on prevention in the kids, smoking prevention, wellness clinics for youth, adolescents, adults, women and men
- Prevention is major source of concern that has not been expressed by the current health care system
- Paternalism, dependency syndrome exists among non-Indians as well, the doctor is God, the gatekeeper
- People have become so dependent on the doctor that they have forgotten that the dependency rests with themselves
- We need to change the way we address things
- We have change the attitudes, as small as they may be, will take generations
- Working with Eastern Regional Health Board, the concerns in the native community are no different from the non-native populations
- We need to change the attitude of the Department of Health
- 4 years ago met with Department of Health, told the Department of Health did not help fund communities because they were federal responsibility
- The First Nations are Nova Scotians, they need to be treated as such, accessibility to programs is limited by the attitude of the Department of Health
- Shows the different ways in which primary care is delivered
- Will attach the primary care document with his book
- The province should establish an aboriginal district health authority

- Big concern, serving in isolation, raising this through tri-partite discussions
- Lack of inclusion in policy making within the system

- Province continues to resist including FN in policy and program
- Difficulty accessing services at the regional hospital
- Regional hospitals are key to establishment of the new system

- Accessing services, process is so slow that contact is limited
- Trying to receive services off reserve let alone in the community
- Health in our community has a low profile in the provincial scene, other issues seem to take priority
- Difficult to live in community where you can't access the service and then go outside the community and find it is worse
- As a worker, let alone as a patient, to wait 7/8 hours is ridiculous
- Assessment on the reserve is not respected, the decisions made on the front line is disregarded by the people at the hospital
- Organization established in early 70s to treat addictions, just now getting into mental health issues
- Most of our clients who are addicted also have other issues to deal with, mental health issues, e.g., fas/fae
- Takes 6 to 10 months to get an appointment for kids with fas/fae to be seen
- Language barriers, many are unable to speak English
- The treatment is not appropriate, returned to the community with more pills
- Fewer workers with addiction background, need to address physical, sexual abuse
- Need to have Mi'kmaq people in the hospitals as interpreters
- Many gaps in the assessment protocols, no communications from hospital to community
- The hospital talks about making mental health services more community based, Truro makes it happen, Sydney does not assist this process

- One gentleman in 20s knew he was about to flip, called crisis line, let them know, will go down to out patients department and pass along the information, still has to go through triage, should have gone right into mental health there and receive service without going through
- Yesterday - physical, social, mental problems, needs to be in hospital, is at home, needs a Mi'kmaq person there to interpret and make her feel welcome, etc.
- The courts is a whole other area, we have a Mi'kmaq interpreter, but this is not a professional person
- English is a second language

- There is no discharge planning and communication of this plan to the community that needs to follow-up
- Transportation - fed government provides transport to medical appoints
- Is some transport for other issues, e.g., detect, however some of the carriers cause more problems, e.g., providing the transports with pills or alcohol
- Counselors are burning out, major problem for the police
- Carriers are hired by chief in council

- Diabetes is problem
- Mental health issue
- New centre isn't even looking at this issue

- Youth is another area of deep concern
- Unable to get a drop in centre
- In many native communities, there is holistic approach to health, things are not treated in isolation
- On the flip side, the centre is treating only the body
- Shortage of workers in most communities, more problem than Eskasoni
- Still dealing with then residential school history and its sequel
- Grossly undefended for all services
- Funding issues with federal/provincial/band creates major problems in any program policy, development and implementation
- NS provides no money to reserves for mental health issues as opposed to Ontario where many $ are paid to communities
- Sending addicted people to psychiatrists gives more pills and more problems
- Psychiatrists giving drugs directly to the patient is also creating a problem with the addiction people
- The need for cultural training for physicians, nurses, all hospital staffs
- Have had credibility problems with accessing especially hospital services, the staff are not respected by the hospital staff
- Need to be concerned about services available for the 0 to 5 years, prenatal care, education, nutrition, social interactions, kids development, growth, we have no services in terms of this
- The healthiest families on the reserve are those that did not have residential school experiences
- Smoking is increasing on the reserve, increased selling to children on the reserve
- We need to be able to educate the parents who did not have the elder role model
- We need to be able to teach the kids
- This requires time, money and resources
- Need to start with the youngest kids
- Also need more services for seniors, youth and kids

Glace Bay

- Member of activist committee, don't use the Denmark experience and cut off care at 65
- Concerned about psychogeriatric, patients being slipped into acute care beds, mixing the types up is creating a problem
- Need long-term care extended pyschogeriatric beds - PHC should put this on the top of their agendum to lobby for these beds

- See role of PHC as advocating on behalf of patients falling through the cracks
- If we don't see our role as advocacy we need to look seriously at the continued existence of the PHC, we intended it to be re-constituted to provide the advocacy role
- Committee developed plan for the previous government
- Before you can develop a plan for healthy living you need to fix the problems here in CB first
- Don't tell Johnny to wash his hands in contaminated water
- Don't tell us how to feed our family when the store sits on a toxic site
- Water in GB has 85% more THMs than there should be, the municipal council has not told the citizenry

- They are telling people to buy bottled water, they can't afford this
- It is dangerous to bath the babies in this water

- We need clean water, clean air, good food without the chemicals
- Lives on $10,000/yr
- Put in high tech filter Thursday, plugged today from the junk in the water
- Standing under the water, no soap, breaks out in a rash

- BIANS - submission,
- Applicable changes to policy to treat brain injury as separate disability

- Glace Bay Youth Health Centre (17 years old)
- Caters to the needs of the youth
- Will e-mail points later
- Major rec - in future make sure youth are involved in the decision making process, make sure the youth voices are heard
- Our system must create a forum that will allow the silent voices to be heard, the ones that are ignored
- It would be nice to see youth involved in the system

Three main points
  - 1. Get back to education
  - 2. Get back to everyone accountable for themselves
  - 3. Start to listen to the youth more

- Apathy
- We study & study & study
- We don't make the answers
- We need things easily available, not necessarily high tech
- Come up with a few things that would make us feel better

- More studies
- Since 1993, hack and cut
- Costs have escalated beyond any reasoned thinking
- Top heavy with bureaucrats
- Politicians don't know because the bureaucrats don't tell them

- Look at the home care system

- Home Care was developed in Glace Bay but Antigonish took credit

- We all feel dis-enfranchisement
- This process is not a dialogue, it is two solitudes
- There is no feedback loop here
- We need to make the community responsible to itself
- We need on-going communication

- The process here and involving the PHC leaves me weak in the knees
- I want a response to the question -
- Blueprint - we have not had reform, we have had cutting
- You are not here to listen to us, you are here for a political agendum
- Are you here telling us the system is going to be cut
- We need an accountability from the top down and the bottom up
- The system is spiraling out of control

- Once information is collected, where will it go?
- What is our recourse if 15 of our 16 points are ignored

- We need an independent body that can act on behalf of the citizens of this community
- Elected, not a political appointment

- Meetings should be scheduled around the availability of the Cape Breton representatives
- Dr. Naqvi is in a conflict of interest
- Emergency departments would have been gone
- Services stripped to the bare bones
- CBRHCC - rebuilding
- Emergency department overworked

- Physicians have to stop telling patients to go to emergency after 4 pm, this is unacceptable
- Youth need support
- We need 24 hour clinics in each community
- Youth are taught some things that are then ignored
- Helplessness amongst youth, baby boomers have corrupted, polluted, messed up, the things are worse for us
- Look at high rate of suicides in this area
- We had a gal here who helped but we have lost track of her

- Health Centre sees 200 - 250 per month in the schools, but this is mostly from GB, there is no public transportation from Donkin, Morion, etc.
- The kids are telling us we need to have satellite
- Northside has satellite with 25 people
- Since moved to Glace Bay High we have lost regulars

- We need long-term care day care for the elderly and the disabled
- Need opportunities for people at home to get out and give care givers in the area a break

- e need geriatrician

- Have psychiatrist in Glace Bay - goes to New Waterford and Sydney, looks after everyone
- There is no child psych, no geriatric psych
- There is large gap for youth service
- Traditional attitude that the youth are just going through a stage
- Very high drug use in this area

- The highest rate of schizophrenia in Canada is in CB, related to high drug use among the youth
- Have nobody here to help these kids to get off the drugs
- Hear more now than did 3 years ago about drugs

- We have startling rates of schizophrenia, highest rates of diabetes, cancer, emphysema, etc., much of it tied to the environmental stresses
- Tremendous exposure to toxins making our problems unique
- You can't apply Halifax to Glace Bay, you need to look at the individual communities to see what they need
- You can't use a cookie cutter approach to core services

- It is important to legislate the Canada Health Act in NS

- We need people trained in the environmental illness
- Some doctors still belong to the Flat Earth Society
- Highest level of environmental illness in the country

- Contents of workbook, concerned about the usefulness of the results
- Blueprint was the best and we saw what the Department of Health did with that
- You can help us with this

- We have no communication between us and the Department of Health except the toothless PHC
- It is ridiculous that Dr. Naqvi is representing CB when he is the major problem in CB

- GB and NS and NW have only lip service left and the regional hospital can't cope with the load
- The out patient department is overworked, just build more space on there
- CB was pioneer in cooperative medicine, people still donate to the hospital
- The government stole the hospitals

- Doctors forced out of practice here, moving to states
- Doctors are being replaced with doctors with defined licenses (conditional)
- 15,000 people without family doctors
- Not fair to emergencies when these people go to out patient department
- Government has never offered subsidies to doctors to go to other areas
- Urologist moved to states, emotional turmoil, cuts, cuts, cuts
- When doctors in Glace Bay said there were deaths due to cuts, they were told to shut up and go away

- When the new enhanced emergency department opens at the regional, we will not stand and allow them to take one more thing away from us, we are unanimous in that
- Everything is being cut and moved to Sydney, creation of the regional municipality
- Like thieves in the middle of the night they stole our hospitals
- It is not going to happen again, we won't let them take the rest
- We need to watch that they don't start tampering with our out patient department staff

- We need equity across the island
- Ambulance service stinks, moving the ambulances around to cover each other is silly
- Need to look at the air ambulance and the cost, takes longer to get here than to put the patient in an ambulance and sent

- Cleanliness in the hospitals has gone down since the hack and cut
- Get rid of smoking at the regional hospital
- Absolutely appalling to go to the regional hospital and have to wade your way through the blue air, hard on environmental illness sufferers
- Butts all over the place
- Very poor transit system
- Handy Trams for the disabled has been cut back so much it is ineffective (funded by regional municipality)
- Taxis expensive

- It is silly to see a Tim Horton's in the Regional Hospital!!!!!!!!!

- Some of the dieticians are in a 1970s time warp in the info there are telling their patients

- TriHaloMethane in the water, from organic matter in the water interacting with the chlorine in the water
- Ozoning the water is more efficient
- The provincial government need to tell the municipal government that water is important
- Sydney sewer will be dumped directly into the harbour shortly untreated, 26 lines currently dumping into the tar ponds will be re-routed to Sydney Harbour
- This needs to be addressed immediately

- We need to say that the health care system is sustainable but we need to care for it
- It is ironic that this comes into Canada on the heels of Free Trade

Guysborough Public Meeting

- The PATH project - people assessing their health - started 3 partners - ext dept St FX women's center Antigonish, public health nurses
- Different focus that MD, looks at the whole person, focused on health, not doctors, not technology
- Good community interaction and relationships leads to lower heart attacks,
- Studies done in Saskatchewan & TO - focus is on lifestyle choices, the community can influence this to a great extent.
- Still need to have resources to provide food, etc.
- Whitney Pier, St. Ann's Bay, Guysborough Co Clinic - pilot project
- Facilitator train at ext dept,
- Here 11 small communities, approached service organizations
    meetings then open to people in the community
- Material compiled, asking what makes your community healthy, what factors impact on health

- convergence between the communities, tools developed to assess the communities, each tool reflected accurately their communities, each symbol showed the community and the importance of the interaction in the community
- Need to recognize that each segment interacts with each other section, government needs to recognize that
- Whitney Pier - clock
- St. Ann's Bay - person
- Guysborough - boat
- Person from St FX ext dept will provide a package
- Each community developed a vision

- See the documentation for vision, check list, etc.

- The 3 communities are still meeting with the individuals from other communities to share the information they are generating
- Regional committee has put on a health forum at St. FX
- Recommend that this project be promoted and funding be made available, main expense is training local facilitator, need to understand the local area and be able to interact with the community at large, uses story telling format to generate the data

- Also need to bring the different people from different government departments together to work on all facets of health, what kinds of choices do you have to make and on what values

- In Guysborough, essential service is the hospital functioning the way it does now with beds, 24 hour emergency service and functioning lab
- Local initiative, local fund raising, residents are willing to continue to fund
- Accred shows the superior care they deliver, the kind of service we have come to expect and receive at this hospital
- Don't often emphasize the role of the hospital because we don't expect it not to be there
- Changing demographics, travel distance (45 to 90 minutes)
- Helps with physician recruitment with hospital in the community
- Budget considerations - make people apprehensive about the ir hospital, $100sM deficit + B$ in debt
- We don't see any spending here to have caused the debt, why do we have to continue to cut here since we aren't responsible
- We still take our cuts
- The Guysborough Hospital is a facility that the residents look on with a great deal of pride, feel it is an integral part of the health care for our area and needs to be treated as a core service

- Acute care programs at GMH have delivered quality care, we are able to attract and maintain medical staff and others because of the availability of beds, etc.
- We have necessary lab & diagnostic services, we provide backup for the doctors to make good clinical decisions
- On behalf of all providers, rethink how health care is defined and redefined every 4 years

- Avoid the political intrigue, we are stressing a very important resource, RN's and M.D.S. every 2 to 4 years with the political impetus
- We are beginning to see a shortage here, no longer have a casual float pool to support extra services, they are now being moved down the road to Antigonish
- We believe in doing preventative care, outreach programs such as diabetes, asthma, etc.
- Are working toward, both the foundation and the community
- One of the big successes is the palliative care programme, very positive influence on the life of the family in the community
- All staff at our hospital, and health care in this rural facility we have great potential for patient advocacy, multi-disciplinary meetings every Friday, beginning to make a dent, still missing community services there but we do seek them out
- Advertising for volunteers for palliative care, however, the volunteers are also aging

- Visits patients every week as there are few volunteers, so there is no real volunteer program
- Working well so far

- 3 small community hospitals function similarly to Guysborough
- Same problems, HR, recruiting, budget cuts

- Similar to Guysborough with the same problems
- Now treating patients long after discharge, unlike past when care ceased at discharge
- Acute care is at the base, protects all
- Main concern is per capita funding will create major problems for this area with a small population well spread out over area
- Palliative care - donations are being designated by the public for this service, right up there with the core programs
- Sometimes regional hospital counts their population

- Per capita is a major problem for all of Guysborough County services in all areas

- Cutbacks
- 3 nurses in Guysborough, 1 in a school
- Budget ~ less than 4% of budget for prevention

- Can't keep changing the landscape every 4 years!!!!!
- Productivity decreased
- Staff concerned about the job market
- Good staff that are in their 30s at Guysborough
- Staff is working at 3 facilities

- Good connection with the nursing home
- We worry about other areas getting services at the expense of this community
- Turf wars developing, counterproductive

- A lot of very good active, grass roots services in this area
- Lots of volunteer hours in violence issues

- Will have major impact on Guysborough in the future
- GOALS - 15 people (Guysborough Options Adaptive Living Society) - is helping people stay in community or return to community from long-term care facility, poorly funded, but still works well
- We need to start pushing for support for these

- Local CHB member
- Worked with addiction services
- Need to keep addiction services as a core service
- Now doing prevention work
- We have talked for 25 years about delivering community health service
- Part of difficulty is the emphasis on acute care tertiary services
- A lot of things that got funded through the system got it at the expense of other programs
- We want to embrace Kids First, Family Violence Programs, etc.
- We need to do a lot of work
- There needs to be commitment from the people who make decisions to support these initiatives in the community
- Development comes from the inside out, not the outside in
- Services have to be delivered differently
- Physicians shouldn't be the gate keepers

- None of the prevention/promotion things have happened yet although we have been saying this for years
- Acute care services need to be funded adequately, but we also need to put more money into wellness
- How do we keep everything for illness, support death with dignity and also enhance prevention

- Guysborough County has employment problems
- Invest in our youth to keep the community viable

- Excited about Health Goals in booklet
- Especially environment, key part of rural living
- 1 area needs sewer
- 1 area needs water service
- Social justice is especially related to rural NS
- Need to ensure that all Nova Scotians have healthy soil and healthy water
- Key priority - need to have quality patient care, it has eroded so badly recently, especially mental health and physical health care delivery
- Little follow-up, stay in motel, unhealthy, no dignity, brought in by number, sent to motel, with family who have no idea what is wrong with you
- Doctor in Antigonish says he is overworked and underpaid - shouldn't be complaining to the patient, the patient is there for service not complaints
- Guysborough pays the same taxes, didn't accrue the debt and deserve the same level of service as others
- Get back to quality health care
- Make sure that you address the social justice and the environment

- Workbook is written to high level
- The people who need the service may not be able have input as their reading level low

- Sitting on Mental Health Committee with ERHB
- Few services in Guysborough County
- The sole worker is on maternity leave and not being replaced for 6 months
- The whole mental health services needs to be looked at as core service, increasing stress

- Used GMH this summer
- Speaking in support of the local hospital
- 5 years ago had surgery at New Waterford
- Had mother in 2 regional hospitals - service was poor, condescending in local regional
- Father in St-Richmond, good care, good attitude
- The regional hospital turfs you out to the motel, poor service

- Concerns about the home care programs and the downloading of taxable services on to the family
- Yes family should have responsibility but should they be providing the medical & mental health services
- Not enough support for the care givers in the home
- The care givers lives become the people they are looking after

- Little respite available
- The promised support for home care hasn't materialized
- A lot of money went into administrative support not front line workers
- Having to refuse services because they do not have enough staff to support the program
- Then the family becomes more taxed as well because the service is not available
- No coordination of the delivery of service
- A lot can't be done, the care givers are suffering as well

- More referrals
- Some areas have no staff to support these referrals
- Care givers are being stressed out
- Had a big surplus every year, it was taken from us this year
- Respite is 8 hours per week here, the Metro area is giving larger numbers, makes it very difficult in this area when the Metro tells patients being d/c that the support is available
- Now trying to locate another doctor, plus local doctor trying to set up practice in Antigonish
- No taxi, no public transportation if doctor leaves
- Other communities will also lose their service if Mulgrave is unable to replace the doctor
- State of the art facility there, fully equipped

- Dentist in Guysborough is cutting back because people don't go
- Dental care after age 10 has been cut and we can't afford it any longer

- Many care givers are women, many have to work outside the home as well as look after the families

- Don't make any more cuts in the rural areas

- Communities provide many services you will lose in a move to the urban centres

- New to community
- Criticism of the letter
- Concerned about what will happen to the information after we have compiled it
- How do we ensure the government listens

- Transportation study through 2000, one of 3 pilots in province
- Seniors disabled

- 1 solution
- Follow the money and see what has happened
- We need to refocus away from doctors and drugs where we spend a lot of our money

- We need to focus on prevention
- Get environment, health & finance together to look at how the 3 work together to contribute to health
- Water, sewer, etc.

- The cabinet needs to look at the system
- Bed blockers in the big centres
- If you close local beds you have nowhere else to send the bed blockers
- Look at nurse practitioners (4 projects)

- Shortage of nurses
- We need to go back to the diploma grads working for free during their training period
- Closing the hospital based programmes was a mistake

- Doctors need to go out to rural areas during their training sessions to see the reality in rural Nova Scotia.

- With the volunteer work and contribution to hospitals shows that people are willing to dig into their pockets to pay for the services.

St. Pat's High School
Halifax

Issues brought forward:

- I would like to see improvement to the health care system;

- What is government doing with Community Health Plans & Community Health Boards
- What will come of the results of this meeting
- What is the new CEO of the QEII doing
- Want some action

Care for seniors
- Need statistics on who needs home care
- Need wellness programs in the community to promote wellness and for seniors to stay in their own homes

Mental health services for children and adolescents
- Don't have enough good quality facilities to deal with those who are ill
- If we catch them younger, we will help them and save the health care and justice systems lots of money later on. It costs so much less if treatment and prevention early than if we wait to send them to jail or institutions
- Why are children not covered by MSI for mental health services?
- Children should not be taken out of their own homes but helped with services

What does it mean to you to be healthy?

- Living in a half-decent place with enough to eat, heat and light
- Recreation opportunities
- Healthy food in the grocery store: young people have problems due to additives
- Having friends around
- Being an active part of the community (church, etc.)
- Feel safe, secure and loved
- No garbage in the streets
- A place to go for medical advice on evenings and weekends
- Lights (that work) in the streets
- Police supervision in the middle of the night
- Feeling useful
- Knowing that there's a way to be heard. If there's a problem there's somewhere you can go about it (e.g., an ombudsman)
- Snow shovelled - neighbours helping each other
- Strong community centres: places where people can meet
- Need to feel that when we make submissions someone listens. It's hart to feel healthy when you feel helpless
- To feel safe in your community
- To feel that the government is accountable
- Have a parallel position to the provincial auditor for health
- To be mentally engaged
- Encourage people to take part in a crafts, hobbies
- Transportation - an infrastructure to provide for those who do not have private vehicles
- Bylaw enforcement
- Ways to be able to feel engaged in life
- Opportunities to be with other people

- Access to all determinants of health
- Able to cope with stress (e.g., security from cutbacks to the health care system)

What does it mean to you to have a healthy community?

- Safe
- Working together
- A sense of neighbourhood
- See above

Other Comments

- Stop studying
- Let's have a re-commitment to the principles of the Canada Health Act at both the provincial and federal levels
- Be sure to send this information to the CHB and to the local newspapers
- There are no "core" services: all are core because they're all inter-related
- Need an increase in children's dental programs
- Need to look at what are the services needed in each community to achieve a healthy outcome? And to prevent poor health outcomes?
- When you work for outcomes you have to work inter-sectorally
- Communities need to be environmentally safe

Inverness

- Nurse's training in the states
- I believe in our medicare but there is less waste, more accountability, etc in the states where the hospitals are private
- As long as no one is deprived of care we should allow them to do this if they are able to be more efficient
- If we had more competition and less structured barriers we would be better off, but there would have to be some rigid structures in place
- Would lead to improvement
- Having worked in private hospitals and public hospitals in the US, where there is some disclosure and emphasis placed on education we would get more bang for the money
- We need to see more community hospitals and less amalgamation
- They would be pressured into giving better care

- Also trained in the US
- In a big hospital in the States
- Then came here
- Less waste, carried sheet to account for everything used, a charge slip
- Did lose your communication/empathy with the patient because it was so business-like

- Recently became aware of the poor ambulance service in this area

- In Inverness they are among the best in the province, know area
- Dispatch unit is one totally screwed up place
- Transfers - the emphasis is on emergency care - having to wait an hour and a half for ambulance is terrible
- From Cancer Clinic in Sydney - the public isn't aware of it but we have to deal with it every day
- Mom had appointment 10:15, booked ambulance for 7:15, it arrived at 8:15, that is not good service
- Challenge the Minister of Health or Transportation to take a trip by ambulance from Inverness to Sydney

- In Margaree, a committee formed to look at the response times for ambulance service
- Last Saturday for the whole day, there was no ambulance available from Pleasant Bay to Port Hood
- A call was made in Margaree for transport, took 46 minutes for ambulance to come from Baddeck
- We have talked with Arnold Rovers and Mike Murphy and they feel the service is adequate for this area, we think it is not
- The Municipality is also looking at this because it just takes too long

- We were served much better by the old system

- We need to know why the ambulance is being used, patient transport is different from emergency care
- Sometimes maybe we misuse the system as well, there are two sides to every story

- Emergency transport is no better either, the limitation is a lack of personnel, you don't know where the ambulance is and what it is doing, as soon as 911 finds the ambulance you will know where it is
- The plan was to have good coverage, the plan was good but didn't take into account the geography
- The rural areas heart attacks are just as important as those in Halifax
- You need the emergency response within 4/6 minutes

- The ambulances here must buy their diesel fuel from Irving, e.g., Margaree, Whycogamah or the causeway

- I have a scanner, 911 reports the number, the ambulance asks what part of the road that is on, 911 doesn't know
- The local dispatchers used to know the area, but Halifax dispatchers have to say they don't know

- If called to go to 1 hospital, the ambulance driver may elect to go to another hospital, usually the closest facility

- Make it known the services provided in the Red Cross

- Some in support of health services
- Some in education
- Inverness / Mabou / Margaree / Cheticamp / Port Hood
    - Hospital equipment loan program
    - Very good service, some generous donations
    - Water safety program, swimming lessons
    - Emergency services, house fire - comfort kit, accommodation, clothing allowance, etc.
    - Disaster response training program in the community, evacuation
    - First aid and CPR training
- Some community services, some with ambulances, families in need unable to provide transport to Halifax, etc., volunteer transport program
- International services, Canada helping other countries
- Abuse prevention services in other areas, e.g., Halifax & Truro part of home care services

- Was a member of Eastern Region Health Board
- Maintain the secondary services we have and enhance them a bit because of the geography like OBS and surgical services

- Echo above
- Also need to have money put into education and prevention, fund ongoing programs for more than a year at a time

- In book - eliminate the column 1 place in province

- Clinical service review across the whole province
- Looking at what is feasible to deliver
- Look at what is important to us, what will we be able to keep
- Adding prevention / promotion, etc., will cost additional dollars

- Keep all the acute care services in Inverness
- 32 beds with 12 long-term care patients in them
- We need more long-term care beds, enriched housing, etc.
- In Inverness problem 66% of population of Inverness is over 65 years
- Need to something in the next few years about this
- The government is not putting its money where its mouth is
- In the community it can do lots free
- Walking club here at school, we have no mall, 6 or 8 people walk

- We need to start the program when the kids are young, it will be natural to continue to do it at 65

- Cheticamp - 47 names on active list and 120 on waiting list for placement, active should have been here yesterday
- Long-term care patients are blocking the beds in the acute care facility of 10 beds
- Neighbour's father can't be admitted because of this blockage so he was sent home

- The reality in small communities is that the hospital means jobs for the community

- Palliative care program in Eastern Region in its infancy, we have had a few who have been able to die at home with their family, but this takes a lot of effort on the part of families and the service providers
- This should be a core service in this area as we have such a large senior population

- The P3 school in Cheticamp will be setting the community back to 200 years ago, adding 50 km to an already long trip for the kids grade 4 and up English students
- Had a CHB meeting in Pleasant Bay, terrible travel conditions
- Is dividing families, some entitled children and some non-entitled, Pleasant Bay is asking for additional mental health services to deal with the stress this movement is causing

- A lot of the problems are at the base of the transfer payments for education, health

- Inverness is 2 hours away from other service delivery area
- We need to keep the things we have now because of the geography

- Dentist
- We have a hospital; here and one down the road
- We are the smallest hospital in the province with an OR
- Dentistry, request for OR equipment has been oked by Eastern Regional Health Board so we will be able to continue to provide dental OR services
- Dentistry, nursing & medicine all come together to provide this service in a safe environment
- Service for pre-cooperative kids (under 18 months), and special needs adults
- We as dentists rely
- We are receiving referrals from St area, Sydney, etc.
- Someone is looking after these programs
- The IWK has waiting list of 1 year for these kids, in Inverness our waiting list is 1.5 months
- If the OR is changed or downsized the little kids don't have a say will be affected and they are not even taxpayers yet
- In NB they charge the fees since it isn't covered by provincial insurance
- The services will get done but we have a system that looks after the disadvantaged by age or other reasons, but we need to keep this, we can't manage better the system we have right now

- Core in the school system should be health education and illness prevention so we don't have to start teaching it to adults
- We also need to maintain the 24 hour emergency
- We also need to maintain the human resources to do this
- Rural areas we need to look t multi-skilled individuals and treat rural communities different from tertiary centres

- When the schools are build, what kind of nutritional programs will there be there?
- There should be some criteria for the deliverers, the quality, choice
- We all want to keep our hospitals and our schools as if we lose one or the other we will lose our community

- What is the point of having all these hospitals of we don't have the staff

- Hard to get young people to go to nursing school, come out with debt and be unable to get a full time job. They have to go to Texas for a job

- We need legislation for the nurse practitioners in order to function
- We are living in a physician driven system
- The rest of the province needs to support this

- We have no board representing the area since the regional health board was dissolved so all decisions are being made by the deputy minister, we are concerned about this
- Get on with the regionalisation of services
- Get home care and long-term care designated under the DHAs
- Single entry is necessary

- Rural area, problems with ambulances
- Could CPR courses at $50/60 per course be subsidized

- Clerical staff is important too, it is not good use of RN time to do this
- No clerical staff in Cheticamp, its every man for himself, need this

- Don't make the same mistake of introducing DHAs with reduction

    - Need in all communities - physiotherapy and OT
    - Chronic shortage of these people
    - Shouldn't have to wait a year for chronic pain treatment
    - Public health services
    - Good prevention will help reduce the need for the ORs later

- Rampant dental disease has shrunk
- The ones you see are the ones whose parents still give Carnation with 2 tsp of sugar and get a good night's sleep
- Education works

- Home care needs to be enhanced and expanded, it keeps seniors in their homes
- It does work
- It does alleviate the health care system

- Number 1 problem - heart disease and cancer
- Could we have mobile CXR vans
- Not one smoker in the room
- The care is good for someone with a heart attack but one with aneurysm won't last 10 minutes

- Define community, district, region

- Don't have follow-up for cardiac, etc.

- Defining community as catchment area of hospital, region as CB, one in province I don't like

- What expectation is being put on the consumer to make healthy choices and prevent ourselves from getting sick
- If a person brings a condition upon themselves or someone else do they just get away with it?
- Is there any consideration for user fees for individuals who bring these things on themselves like smoking, drunk drivers, etc.

- You need behaviour modification programs for these changes, the community needs to be entirely behind this, there is a lot that can be done, but it is a lot of work
- Rural need to maintain the air ambulance, it has made a difference in many cases
- Our fear is that the air ambulance will be used inappropriately because of the problems with the ground ambulance

- Prevention - every April CHPF - good grant program - got 1 for seniors prevention program - paid for equipment, videos, etc.

- The system is under severe assault
- Vultures circling to get private system, that will provide excellent care for those who can afford it and none for those that cannot
- We need to improve it, the private sector can't improve it but they can profit from it

- The HMOs are run by Satan
- US senior citizen's pay $700US per month for health care
- Our system has great specialists, the fact that they are here is a testament to Canada
- Don't go to a private pay system

- Manage health care facility
- Has not had an increase in operating budget in last 10 years
- Cannot tolerate any waste in system because of this
- Long-term care facility

Kentville

- Public participation is a critical component of the health system
- Support physicians for Kings County - important to have doctors
- Cancer Care Nova Scotia - related to medical oncologists. Group learned a lot - found utter chaos, no data base as to what the system does, no information on how much program costs. When making decisions have no data on which to make it. There is no health policy. Needs to have a new approach - thought, imperative to do something different. Move health care out of the political arena and make it a crown corporation. Auditor General has been scathing about the financial situation in the health

Psychiatric Mental Health Care

- 1-800 # is wrong
- Hospital beds for psychiatric beds. 50 in Western Region (135 outside Central Region - gave numbers in other places)
- 22% of young Nova Scotia women report symptoms of depression, 1/7 of Nova Scotians report symptoms of depression, 12% between 15-24 have 1 or more psychiatric disorders
- Challenge to get a child into IWK for mental health issue, gave numerous other stats
- Mental health services are the lowest priority of any other issue
- Spend the money we have on the ____ of the health issue: (not asking for more money, but redistribute those we have)
- Why is the money received not distributed more equitably

- Brain injury not recognized as a medical condition
- 17-35 years
- Rehabilitation programs have not kept pace with needs
- Peter's Place - private, need money or insurance
- Ashery House - private, for 3 services
- Departments of Health and Community Services provide some supports, but what is available does not meet the needs. Need for services from onset of illness/accident to rehabilitation. One woman as personal experience as had a son who received a brain injury via a MVA
- 12 unit brain injury unit proposal submitted to have a program in Waterville

- Spokesperson for Health Action Coalition of Kings County
- Asking for support and endorsement of actions
- Concerns go beyond acute care - concern about inequity of resources to Kings County
- Have information sheets and petition - looking for something in the area of resources
- Kings County is unique - largest population in Western Region. Largest population of baby boomers and pediatric group. Study projected growth patterns (1991) in province, 16.4% between 1991 and 2007. Many will be over the age of 45 years. Two growth areas in province, Kings County and East Hants, makes Kings County unique
- Contribution that has been made to health care reform and Nova Scotia and fiscal restraint by Kings County needs to be acknowledged. Between 1991 and current - have lost 56% of acute care beds in Kings County (rest of province lost 32%), 1.6 beds per 1,000 in Kings County - lowest bed per thousand count in the province (region 2.7/1000)
- Want more resources - want more beds and need more long-term care beds. What has been lost is the role of community hospitals in a community. No option to access respite, palliative care, challenges with long-term care (acute care facility not the right place for long-term care)
- Join our cause, write MLA, premier, other decision makers - Kings County needs more resources to ensure that we are

- Didn't express my concerns through the structured workbook - have gone that before
- Kings County is uniquely situated in the health care crisis - how does this impact on me - and my patients? Spend more time nursing the system than nursing the patient. Patient care is directed by space and resources - not by the needs of the community. (Applause)

- More time assessing why a patient should stay - decide everyday who stays and who goes - patient - can I get back in when I need to. Will I have to stay two days in the overflow unit
- Art and a science - value being with patient - clearly situation in Kings County places nurses in a compromising position
- "Patient on the end of this system and they are being lost in the shuffle"

- Other aspects of health that contribute to acute care
- Need to spend time on wellness, work of community health boards. Find out how people can take care of their own health so they don't have to go to the hospital
- Almost losing the idea of wellness - until we do this, will have more problems with acute care
- Each responsible for our own health - trying to keep ourselves well. Have the care and concern of doctors, nurses and other health organizations
- Congratulations to PHC - are volunteers

- Community health board credibility and visibility - not a part of the hospital. Need a community health board office that is visible. Pro-active in wellness versus illness. Need money to do this

- Mandate is not clear - vague roles/responsibilities. Need clarity between community health boards and DHA's. Clear, precise

- Poverty and its impact on health - poor kids don't do as well - don't have access to transportation to get to hospitals. Have pockets of poverty in our community, empowered to find solutions - how you get the working poor involved. Tell their stories. Design a strategy - need to hire someone, can't expect

- Continue to fund programs and services that promote wellness - plan a holistic approach across government departments. Make public aware of what's already in place

- One entry point for all provincially funded services

- Nurses - larger role in health care. VON services - could do a great deal. Home care service is conf

- System must be revisited - adult day care, tax incentives for people caring for their family members at home
- Emergency at Valley Regional Hospital - seems to be a problem. No 24 hour clinic available in the area. Department is underfunded and understaffed. More funding, more beds, after hour clinic, hospice for long-term palliative care
- Support the work of the community health board

- No one single thing that promotes health
- Situation within primary health care
- Eastern Kings Memorial Hospital closed 6 years ago - create a transition team which conducted a needs assessment (view to CD and community needs assessment)

- Reviewed health determinants - as in the needs assessment completed, each area was represented. Didn't talk about illness needs, they talked about what they need to be healthy
- Directed transition team and assisted in formulating the community health board
- Good primary health care - health promotion (Red Door for teens in Kentville, clinics for women and men, help with addictions, expanded physiotherapy, OT, medical treatment when needed)
- Community health centre working group to explain the principles to others in the region - discussion paper on community health centres. Shared the highlights of the document - approved by the Western Regional Health Board in June of 1998. And there it sits...
- Eastern Kings Memorial Hospital is a mere shadow of what it could become
- PHC - examine community health centre model as a means of delivering holistic

- Department of Health to use projected demographics to begin planning for aging population
- More acute care beds in Kings County, more long-term care beds, broader range on housing options, augmented palliative care (increase physician and other health provider support in the region). Coverage for meds/equipment for those choosing to die outside the hospital
- Meal programs, peer counseling, recreation programs
- Public transportation system that meets the needs of rural seniors and disabled persons
- VON have a great deal of expertise and VON/other organizations should be invited to be involved in planning programs and services
- Legislate community health boards supported and strongly support the re-introduction of

- Health care crisis - Kings County is drastically under- resourced in comparison to the rest of the province
- Our fault - "we have put up and we have shut up and we have taken what they have given us. We are being strangled and we didn't know about it"
- 6-8 weeks for patients with cancer diagnosis to be "worked up" and to get to the operating rooms
- Much experience, something to be proud of - "silent regional hospital" - time we made our voices heard. Deserve to have the same access as anyone else in Nova Scotia

- Kings County population growing
- Dialysis unit information - Western Kings Memorial Health Centre
- Highest population 14 years and under
- Western Kings Memorial Health Centre
    - VON adult day centre
    - VON foot clinic
    - VON ____ program
    - EMC office
    - Mental health services
        2 to 3 day a week service
    - Public health services
    - Community health board
    - Massage therapy
    - Family physicians offices
    - Dentist

- Oral dental surgeon
  - Health centre itself

- Additional information from community health plan
- Health concern is for the health of all people - meetings like this not always representative of community
- Carry out a telephone survey
- 300 questionnaires over the phone. Some refusal to answer questions - i.e., addictions, family violence
- Difficulties in employment (part-time jobs, minimum wage, seasonal). Poverty is #1 determinant of health
- Addictions - destroying community life

- Lack of environment

- Lack of services/accessibility. If poor, suffer at home. Poverty is an issue that needs to be addressed. Many needs - public health less than 3% of total budget. Hate to hear put all eggs in one basket - need to look at those who get no programs or services because they are poor. Quote re: poverty "narrow - inclusionary criteria" to select clients - permanently existing under class of the poor, they suffer and children suffer. Family incest, drug abuse

- Meet over a week to complete drama together

- Continuity in care - one person to relate to bring things together. All proper co-operating with a known diagnosis - clear diagnosis
- Need for hospice for those who won't be cured, special care for than diseases that do not fit well

- Specialists services provided at Valley Regional Hospital which is in danger of
- People still need acute care - and the services at Valley Regional Hospital are second to none. Every speciality receive medical training at hospital. Most traumas can be treated successfully. Chemo unit is excellent. In order to maintain need money and complex equipment. Have one out of date CAT scan. Specialists are overworked and overburdened. Need a call system - enough specialists to relieve the ones that exist. There are rumours about core services in regions. PHC - unique special situation is maintained and improved

- PHC - environmental illness in schools. Multiple chemical sensitivities are being seen in - many people in Kings County with chemical sensitivity. Need research

- Need to work toward knowing more about genetically engineered food and promote labeling

Liverpool

- Rumors have always been on the street
- Determinants are being dealt with by the municipality

- Close to 30% unemployment of youth, 17% in general population
- Education - 48% have less than grade 12 education

- Core Services
    - From hospital - 50 years - family practice, general practice, surgery, obstetrics, laboratory, radiology, emergency, beds
    - Problems of province - high debt
    - Look at costing of health in Nova Scotia
    - What is happening with province is chaotic
- Problems spilled over the region
- Ad hoc approach created problems in Annapolis, etc.
- Unusual as still have internist, surgeon, anaesthetist
- These are appropriate for a community hospital
- Recruiting is getting more difficult - changing culture. Queens still striving to maintain the past style of health care delivery

- Got phone call from Toronto - brother taken to closest hospital - shipped on elsewhere - put on gurney for 2-3 nights - finally on bed - recommended sent home and back in hospital on gurney again for 2-3 days

- At Queens General Hospital - put to bed immediately and helped. Wants services to remain as good as they are and even better

- Questions seem to be a trick
- Need to have an either/or choice - we don't want to lose anything we already have

- A useful exercise - but we've done that
- Done here - Community Health Plan
- Look at that
- From away but here 13 years
- Just keeping Queens General is not the only concern - that is a narrow view
- A lot of fiscal changes over the last few years
- Regionalisation didn't create a large problem here
- Now rules changing again with DHA
- Don't know what the new rules will be
- The citizens are interested in determining what happens here in Queens County
- **We are interested - we are ready to live in whatever system is set up as long as we are involved in the decisions and staying involved in what we have**
- **We don't know who will be running things here**

- Here about 15 years
- What makes it work here
    - Family physicians make it work - resp., attitude, willingness and desire
    - Community supports its institutions
    - All doctors cover emergency
    - 7/8 cover obstetrics

- A unique setting from physician manpower point

- Citizen
- Concern about the cost of health care - they have built the tertiary centres with great debt load and left the small community hospitals with its doors closed
- Was a very cost effect $345/person in Queens, N.S. $750/person at Glace Bay
- Services should be at community level and regional level - but different level of service
- Need accountability in the system
- Every facility should be accountable
- Don't make elderly move away from their community for services
- Regional boards haven't been accountable
- Not saying go back to old system but make the provider organizations accountable
- Volunteers and public input will make the community healthy

- 15 years
- Major determinant of health is the ability to control your environment - major problem with regionalisation/development of a faceless bureaucracy - loss of community volunteers and support for institutions
- Silos on Hollis St.
- CMA Board of Directors
    - Looking at future of health and medicine for 21st century
- NS PM Board
- CMA document
- Extremely convoluted subject - $200,000
- With informed public debate

- Canadian Cancer Society
- So far no mention of volunteers in the health services of the community
- Volunteers are burning out - more services are being joined as government withdraws the services that volunteers provide

- North Queens - lost its doctor a number of years ago (10) - set up a clinic out there
- Parents established a healthy breakfast program
- 25 miles from Liverpool
- Heart Health Program
- Walking programs
- Don't spend a lot of time researching - just recognize the needs
- Parents doing tooth brushing program in the school
- We can do all this because we have the core
- Two physicians who can help you when you fall
- Visiting lab collection services (God love 'em)
- Have ambulance service/First Responders
- Diet program
- Most important to maintain medical doctors, clinic, lab services - basic needs
- Queens is a healthy community
- One message - we are not willing to accept less than we have now

- Nature of Liverpool
- Born in Queens General Hospital
- Dad served on hospital board with a sense of pride - not an obligation
- **A healthy community is a community that has pride in its achievements**
- Regular blood donor - 38 - with 79 units of blood donated
- The hospital says it cannot collect the blood locally for use locally - hospital needs blood regularly - why can't the local area do this for itself

- Mother of special needs child
- Has to travel to Halifax ½ times/week for her care
- The local service helps prevent her from having to travel more frequently
- If hospital wasn't here - they would have to move

- Recently retired to here
- What will the report contain?
- That Queens General Hospital will definitely be one of the recommendations

Sport and Recreation

- Opened rink in 1971
- Never in red
- Always run in black - lots of volunteer help
- Give us a chance and we will make anything work

- Local control at the board level was good because you could hold them accountable at the post office or on the street when things go wrong

- Observation
- Aging population - hospital won't do it all. We need the community to mobilize its resources to help people age well - this is as important as the health care

- Our community is a healthy community because of the community support for the programs offered
- Volunteers are supported
- Able to achieve what we strive for

- Here for a few months
- Agree with me that paramedics have had struggle
- Strong message to J. Muir to maintain the EMS as it exists - a great program in Nova Scotia - as good as elsewhere in Canada

- Here since May 27. Previously in Margaree
- Increased calls
- Aging population here
- Fear that First Responders would cost ambulance service

- Caledonia has First Responders - commend them for it because ambulance can't get there fast enough
- Not just hospital - all community pulls together

- Parent of special needs child
- I love all you old people but I hear nothing about the children
- We have lots of kids
- Travel to Halifax 2 times per week
- We need services locally
- We are freaking out because of lack of service locally
- Need to look at additional services for children
- We need to keep the services we currently have and more for the children

- Different between here and Shelburne
- Shelburne lost services in the last round of cuts
- We need to keep what we have
- Shelburne is not a pretty sight

- Future Directions
    - #13 - Home care and long-term care services
    - Will abolish the board at Queens Manor same as they did with the hospital
    - Is this what we want
    - We don't need someone in Cornwallis or Halifax running over long-term care facilities
    - We need to keep local control - keep what the community builds and develops in the community
    - Ensure #13 doesn't mean the ____ of local boards

- Long-term care - owned and operated by ____ of Queens
- Upgraded facility (Western Regional Health Board)
- Average age 73 level I care
- If Queens General Hospital not there
- #8 Highway Liverpool/Caledonia
- Won't stop to draw blood as they drive by
- Bridgewater shouldn't make decisions for Queens County
- Need to keep the Queens General Hospital
    - The doctors speak at the public level
- All doctors great
- MD on staff - always covered by other doctors when away
- Respect for all staff at Queens General Hospital
- Local money raised shouldn't be touched by the provincial government
- Respect for everything and everyone in the community

- Town does a lot to improve its health
- 35 years ago was the crazy English lady who liked to walk
- Now have
- Teenagers shouldn't have to drive around the idiot loop - we are worried about them

- Education shouldn't think about music, physical education, etc., as frills
- The education situation needs to be fixed to address the needs of all the kids

- Slippery downhill slope
- Financial benefit - physicians locally, e.g., saves travel money to Bridgewater
- Cab work - local - don't have to drive away
- Time - financial incentive
- Private physician clinic local but not able to pay for the service with coverage

- What is the next step?
- Stressed because she doesn't know what will happen next

- 5/6 years ago - Queens county made a plan to integrate health care delivery in Queens County
- One problem with current system - stifled ability of local community to take control and innovate
- The communities needs to have the power to innovate and control their own destiny

Louisburg

- Recent reorganization of department, has it affected us?

- Why is the information we are collecting being channeled through to the Minister of Health rather than the Premier if health crosses all boundaries? How can we get this info to the right people?

- It will be a slow process if the info is not shared with all the right people

- The reality of brain injury in NS, there is lots of support for the initial physical injury and little support for the follow-up of the cognitive impairment

- Brain injury is not well recognized for what it really is. We should move away from putting our brain injured in jails and mental health facilities and started treating them as physically injured individuals for support and treatment

- Communities need to be supported to develop programs to support the individuals in their community, need for centres in communities, memory book program, life skills training, opportunity to come together and be productive, strengthen self esteem, need for respect for individuals with the brain injured

- The centre helps form relationships, provides a bridge to independent living

- Lack of provision for people suffering with environmental illness, cost and difficulty
Testing blood sent to USA for analysis, unable to be done here, very expensive for the individual
When Camp Hill went the tests were done by MSI while mine were not

Fall River Clinic is tremendous bonus for NS, limitations for treatment because of the waiting list
- Chemical illness develops into cancer, the Health System is failing people who suffer from environmental illness, treated for a long time like brain injury
- Side effects include depression and many other sequelae
- Psychological damage, loss of income related, no longer a productive citizen, people think it is all in your head, that there is no real physical illness
- Reality - can lead to anaphylactic shock
- Unpredictable, 2 choices, sit home and do nothing which makes everyone around you uncomfortable, or go out and try to live a life

- Many people have lost their income and have to renovate the house to eliminate any dust creation, remove carpets, etc.

- Friend grew up in Louisburg with environmental illness. Has nephew with brain injury following car accident. Also has mentally challenged nephew, has no structure to his life, can't hold down a job. Need to have support group, centre to provide service

- If the communities had the positiveness of developing a centre in the community

- 7 or 8 people in Louisburg we can identify with brain injury

- In Ontario, brain injury is a separate disability, in BC it was not, Donald injured in BC in service

- From New Waterford & will make presentation there, focuses on prevention. Have 28 centres across CB, 1 here in Louisburg, shows what can be done with support groups, still prevention is a hard sell

- Need to talk about how we stay healthy. Income is a big determinant of health. Fixed income people can't afford to eat healthy. LICO - just trying to survive. There are very good models across the island. 4 paid locations, 24 volunteered spaces. We need to push the centres, for brain injured as well as other issues. Prevention will help

- Need to get into the schools and explain about brain injury and how it is not disease

- Telling your story has the impact, not the stats, show the challenges, show the life story

- We have to become a pro-active force rather than reactive. We need to get double work out of our public dollars

- Anger management - the people who deliver these are trained only to deliver in their own department

- In CB we work well together at the community levels, but there are some examples where we do work together but then run into barriers in government

- Government needs to hear that it should get out of the way and help not hinder. Help the communities to become self-sufficient

- The granting system doesn't work for projects like Joanne's, waiting lists for pregnant women for feeding programmes. It is often a hard sell. Intervention gets a louder voice than prevention

Millbrook

Responses to the question: "What, for you, is a healthy community?"

- Includes physical health, mental, spiritual and emotional
    - Physical health includes economic health and fairness for such areas as
        - Housing
        - Food
        - Transportation
        - Clothing
    - Mental health includes both children and adults: the band has two psychologists from the Colchester Hospital who come to provide services for children, adults could use the same help
- Good interaction with people
- Support system
    - People to come and help when I need it
    - A chief and council who are open to people and their concerns
- Know what's going on provincially

(Comment: don't want to be knocked off to provincial responsibility)

- Involve everybody to help with the health of the people
    - Traditional healer who works hand in hand with the doctor, nurse and the health team
    - Homeopathic doctors
    - Natural/herbal medicines
- A big current problem is addiction to prescription medications
- A community that goes out and finds out how to respond to crises and needs
- Everybody is responsible and needs to take on that responsibility. The question is how to empower these people to take on this responsibility?

Responses to "What kinds of services from the provincial level would help you to build and maintain a healthy community?"

- Need mental health services
    - Drug problems are related to mental pain
    - An adult has to wait a long time on waiting lists to be seen by the hospital people
- Recreation could be a bit more structured, especially for the youth. Still have people sliding through the cracks

- The ones who need help most don't come out and ask for it

- Training for community members:
    - Crisis intervention
    - Mediation
    - First Aid/First Responder
    - School bus safety: programs for parents, drivers and kids. Help to ensure safety for kids, appropriate supervision on the bus beyond the bus driver and communication between the parents and the bus driver and the particular needs of the kids (e.g., that a kid has to get off the bus at a different place than usual)
    - Bereavement counseling
- Knowledge of what is out there and a way to find that out
- Some people fear coming forward for help (e.g., to the family treatment centre, because they fear being seen as bad parents and have their children taken away
- The province to put up a booth at the community health fair
- Provincial guidelines need to respect cultural differences and needs
- This value (respecting cultural difference) needs to be guild into health service delivery
- Put in outreach from institutions (e.g., psychologists coming to the community)
- Support for alternative health services
- Use of stipends and honoraria to take care of people who "give" their services. This is not recognized by the provincial or federal governments
- Core funding for the First Nations Aids organization, where it is provided for all other Nova Scotia Aids organizations
- Help to obtain grants, etc., from private organizations
- Help with programs to stop young people from smoking
- Laws about children smoking
- Let the native community use processes like "Sentencing Circles" to deal with criminal behaviours. These are much better than sending kids or adults to prison where their pain and rage is increased. It's important to be careful who sits on the circle
- Better access to services: e.g., having to wait 2 - 3 months for an appointment with a physiotherapist, or you can go immediately to a chiropractor and pay for it yourself
- Hold diabetes clinics in the community: people don't like going at the hospital and it's a large problem among native people
- Use a family treatment approach for anything that involves the whole family (e.g., addictions, diabetes, etc.)
- Home care and home support
- Palliative care
- Need timely mammograms and other screening tests such as bone densotometry

Comment: Great model at the Cobequid Multi-Service Centre, for organized, timely services

Musquodoboit

- Have had lots of opportunity for input through community health board

- No reflection on communities that not huge number present. Because done extensive input through community health boards, has been lots of input. Not apathetic in rural communities

- Waste of money to put into this again. Look at what was done before

- Why not move people from Halifax here for MRI. We have to go there. You have extra machine. Put one in Dartmouth and here. Let's move people. If we have one there, we would use it. If don't have enough of us for it here, move people down this way from Dartmouth

- Get ideas of what resources exist. Know what we have and the best ways to utilize them. So close to metro. There's no reason we can't better utilize what we have. Pool resources so we can get the most effective services
- Would be closer to Sheet Harbour than metro to have it here
- No reason people from Dartmouth can't come here. It's no different for us to go there. They can drive the distance. It's changing mind sets
- Basic things - no reason they can't be more efficient

- Can't get funding because data presented is so out of date. Difficult piece (directory). Libraries did work with Halifax Regional Municipality libraries and western region doing directory in terms of Halifax Regional Municipality with services

- Read articles. The purpose of community health boards is to solicit information like you're getting. Will they have to do this again? It's redundant

- Other regions not as progressed as we were. Don't know if asked people on community health boards if they wanted more power

- I think we wrote some of the books for the Department of Health

- It was difficult to swallow because PC's response was to change things instead of looking at successes in central region where it was working, and saying how can we get other places to work. Instead of re-inventing wheel and using money, we need to go into health care. Why not look into successes? I knew it was coming to say to take away health boards and re-establish things and make 9 regions, and it will cost more money. How are we supposed to save money?

- 9 DHA's is outrageous

- New DHA's based on hospitals and maybe will work better but don't say it's under guise of saving money, because that's crap. It's not going to save money. How can it?
- The government hasn't listened to people who knew what they were talking about. I see it as being a way for the government to re-establish its hold on health. Have department in the midst of it. Way it was with regional health boards made decisions based on regions. Now department has hold on it and won't listen to it

- Transportation is an issue. When people can't get to service, it doesn't matter where they are

- Poverty combined with transportation. Can't have good health if too poor. Can't afford bus. Huge issues around poverty. Can't be neglected when talk about health. If can't give people dignity and self-worth and things they need to live. We've said this to community health plan, and they've put it in their report

- If went out and asked people, they won't come out again. Been there, done that

- Don't know extent people in city understand transportation issue

- Poverty is same in the city. Don't have money for bus

- Cost is higher in rural than city because of transportation

- Distribution of resources and satellite clinics. A specialist said who is going to travel to Sheet Harbour to work for 2 hours a day. If this is attitude, how will we get forward?

- Alberta - outcry about 2 tiered system. Have 2 tiered health care because of people getting sick in town and out of town. Costs for people who get sick in rural areas is higher. Cheap, adequate transportation for people who need to get into city

- They would use free ambulances. They don't use public transportation system that's here now. Don't know what answer to transportation problem is

- Some people don't have cars or only one of a (husband and wife) couple drives. Matter of paying someone to drive you into town. Some people only drive in the country. These are crucial problems

- If got essential services, don't have to travel too far. Couple million dollar machines

- Changing attitudes - think a lot have to change. If people from Dartmouth had to come here for x-rays, their attitudes would change. Would see complaints arising from urban area. Think worth a try

- It worked in Nova Scotia Hospital. Huge stigma about going there (it's services are open to the general public). When people found out they had shorter wait times, there was a huge attitude change and now people come to the hospital

- Important cut wait lists by using what we have more effectively

- In 2 hours spent driving to Sheet Harbour, they could see a lot of people (with fee for service). Doctors are not making money when driving. Short of specialists and ones left aren't going to give up time to go to the country

- If on salary amount, don't have to worry about that happening

- Had to get blood taken. Had to wait a week here. Got it done in Halifax in 2 hours. It's quicker to go to Halifax

- They book so many per day. It's prebooked

- Will be lucky if all lab services don't end up at QEII

- Have problem with sending blood to QEII because could be done here in a day

- Wife has prescription from doctor. Can't get it done until next week

- Don't have staff for people to walk in and get blood taken. Bus leaves at 11:00 and takes all the blood (for testing at the lab)

- Can get all blood you like but some has to be delivered right away to the lab. That's part of transportation problem. Have to have transportation

- It becomes logistical problem

- And administrative problem. Certain types can do here but don't have staff to fill it or qualified staff

- If it's too expensive, why not have private clinic and send bill to Medicare?

- If doctor refers to private clinic and government picks up cost, what's the difference?

- It works in England and reduced waiting list. A lot of people have health insurance and can't use it

- Have 2 tiered system. Eye glasses part of health, physiotherapy (outside hospital). You pay for it

- Pay for dentist. What's wrong with that? People accept pay for dentist. Why not other things?

- Focus is health promotion. We are looking at all our resources and pooling them

- I try to promote health. On fee for service basis, can't counsel promotion, or will get behind

- 14 advance practice nurses in QEII. Great shared practice in Middle Musquodoboit. If not built into budget, can't do it. Still task oriented. Not built into budget

- Does anyone not know how to be healthy? We don't do it

- Not everyone has the opportunity to make change. Might know effect but can't effectively do it

- Part is learned behaviour. Teens getting pregnant, teen smoking. Parents smoke

- Teens are getting smokes from families. Only way can see preventing it is to make it illegal to smoke. Do whatever you can to make it less socially acceptable

- Problem with smoking is see high incidents of it with people on welfare. Will make sure they have it, even if children go without food

- Enjoyed cigarettes and would be upset of couldn't smoke when I wanted to. Doesn't smoke anymore. Smoker has no rights. That's other side of coin

Harmful to all others
Concerns: Regionalization
Cost of DHA's
Need for health directory
Transportation
Poverty
Intersectoral problem in province
Good in area
Not good in region and province

- A lot of things at regional level that are changing. Sitting with school board and justice. Work doing in area with school board is really leading edge. When looking to effect policies in schools, made some inroads. This show cases regionalization. There were flaws but good things, too, like this community shared what it is doing, and we've gotten past that in last 2 years that systems are planning together with education and getting there with justice. Think is monumental. Prospect is there for province. Took a lot of work but happened here quickly because had ____. That's possible everywhere if people have time to do it. Between Western and Central Region we can showcase this is working and had made difference

- Three facilities in area community proud of them. Want them, enjoyed input in last 3 to 4 years and want to hold onto dignity and say these are services that we want. Have been reasonable with services we want. Want to continue to look at needs and if services meet needs

- Difficulty is attitude of being fed up because just looked at doing this process. Give changes and everything people said put on freeze. As an administrator never seen people more demoralized and fed up with system. Given over 30 years, made rotten mess and now are pushing people to fix mess. Wanting us to fix 30 years mess in 3 years

- Brain injury people in community poorly serviced. Need support centres, professional trained to serve them and data collected by them

- People on social services are doomed to have poor health, can't get it and are blamed for having poor health

- When gather information, will it be put into major health plan? What is goal?

- A lot of things focused to same thinking (with community health plans)

- Have elderly population in area. Low on staffing at long-term facilities. Waiting list is full. Anything for geriatrics - assessment. Long wait. Not a lot of safe guards in place

- Is all over province. Not talked about much. We're going to be in serious trouble in a few years because not enough staff and beds. We get calls on daily basis from seniors in tears because don't have access to health care facilities, no social contacts

- We have seniors taking care of seniors. 70 year olds taking care of their seniors. Whole mess government made with small options. Good opportunities for people to live in healthy, supervised facilities with small option homes. We have to be more creative and pro-active

- Home care is active in communities and doing good work for elderly. With home care, have increased population

- Puts more stress on staff and resources you have in-house

- It all stacks up. Even with community services. Have to get those people out to classify people and identify if person needs placement

- Lack of resources at all levels

- I see patients released from hospital knowing in 2 weeks they will be back because no safety resources for them

- People doing care at home are getting ill, and the person they're looking after outlives them. Outreach - people being taken care of can be picked up and taken here. Not being funded properly. It's coming out of our budget. Mismanagement. Huge piece and is something we could be doing 5 to 7 days a week if funded properly. Would keep people out of hospital. Could be doing that for $50 to 75 per day. $226 at Twin Oaks

- Need for enriched housing. Like stepping stone but seniors get apartment and nursing home

- Buildings are attached to long-term care facility. They have own apartments but if sick and don't want to cook, can buy meal from long-term care, staff do cleaning. Medications can be given out. Done reasonably and cost effectively
- We should be looking at it everywhere but don't have resources

- Don't pay enough attention to care giver in home care. Care giver needs more attention. And palliative care
- Information management - need to spend money provincially to get system in place to find out what's happening with somebody. All doctors have numbers that allow to prescribe narcotics. Could have number for computer to find out what happened to patient. There has to be something to do this

- Is issue across systems. Could be several people looking after a person and filling out forms. A lot of duplication

- Active committee in region working on single entry. We're actively lobbying for single entry

- Would like to see more pamphlets so patient can get more information. Wait for year to see neurologist. Have questions. Very angry and frustrated. If could phone an office and have them answer your questions. Doctor doesn't have time to answer, nurse doesn't know. If could send you pamphlets. I'm former nurse, and I don't know. Need information

- We don't get information we need from secondary and tertiary care in time. We don't know what doctors did for people. I shouldn't have to ask patient and rely on their interpretation

- We've had discharge information from a year ago and on dead people. No good way because of way system set up

- Long waiting periods to see specialists

- It's proportionate money for health promotion. Maybe if have more money on health promotion may not have as much illness as we do

- Adolescent and family services. Not much out here. Not much for mental health, community support for illness and promotion. Huge cry for child and adolescent services. Can't go unmentioned in report

- Only get funding because we're shrewd with getting grants
- Place in Sheet Harbour. We have some but nowhere what we need
- Children and adolescent mental health is really bad
- When talking provision and talking waiting a year to see specialists if had cancer and had to wait for year, could be too far for them to do anything about it. Something minor could turn into major thing

- That's part of job to decide what's serious. Can push things up if seen something serious

- Number of youth on streets in rural area is scary. Children are kicked out of homes for whatever reasons. It's on the upswing. In last week found 16 year old girl crying on my step. Mother booted her out. She knew I work in health care. Goes on all the time. Was room at safe house here for years. Looking at now with change in legislation abusive male taken out and female can stay in own house, safe house may have to look after our teens. One in five children are living in poverty. One third of youth are unemployed and living in poverty

- Do you find public attitude is someone else is responsible for their health? Someone should say person responsible for my good health is me. Seems would be worthwhile to say not government's responsibility, it's you

- Government now saying family has responsibility to take care of elderly

- Baby boomers have to work and can't take care of their parents

- Need our own money made in Nova Scotia

- The plan started with PC's 10 years ago. Now that things start to work, government changes things again
- We're seeing less politics in old system and worried will get more politics in new systems, and that it will be way for government to get its hands on it

- Community health boards may prevent that

- May get token people and rest from Department of Health. Very afraid

- Literacy is another issue that affects health

- John Hamm on tv saying respect Nova Scotians. Doesn't respect someone and take what they said and turf it (Goldbloom Report - government didn't respect it)

- Going through same performance again. How many times do we have to do this?

- Every time we vote

- Maybe this report needs to be written in plain language. Sometimes can't find your input in reports

- They don't have time to write in plain language

- Tell government to do this effectively need more time

- I wouldn't be very comfortable with time you were given

- There's a way to say everything that's acceptable (she didn't feel people in her area will understand language in workbook). It's more government money spent on printed stuff and people can't understand

Neil's Harbour

- Sharing of information between government departments is a problem
- There are services that each community needs to have to be healthy
- How do we ensure that the services are delivered?
- Cross-jurisdictional issues need to be addressed

- The communities need the dollars to maintain the
- Have addiction services and palliative care here, we need to keep these

- We need to know that we will keep what we have before we even think about adding services
- Too much cutting back has already happened
- If the dollars don't come to keep what is here, the patients can't be shipped to Baddeck
- Geographic areas need to be addressed
- The budget needs to be maintained

- The public - first concern is core services
- Primary health care is the first thought
- Right now there is a staff shortage
- Shortage of psych services
- 1 social worker to deal with entire county of Victoria
- The money allotted is being used for other purposes
- We do not have a dentist in this area, you need to travel to Baddeck or Sydney
- North of Smokey there is no choice
- Physio - magnificent facility but not physiotherapist
- 3 classes of people
    - The ones with money
    - The ones who can eventually afford treatment
    - The working poor
- We are just starting palliative care, the population is aging, labeled as a maverick program, it is in danger
- Long-term care beds are short, there is a waiting list now, what happens when the baby boomers get there
- Elder and child care services, now just a health nurse doing 42% of her time doing paperwork
- The whole problem is it is a numbers based system
- It is costly to operate in an isolated area
- Add in a snow storm and see where you get
- Child delivery, applaud ambulance services
- We have an area that does not do obs, due to numbers
- We send ambulances to Halifax or Baddeck, we need to bring ambulance in from Cheticamp sometimes
- Helicopter services, STAR program is wonderful, but there are times when they are unable to fly in to this area
- What services are we going to maintain
- We need the beds, it is cheaper here
- We need to add the staff, we have to stop having casual labour, give them full time employment with benefits
- Essential services to include and maintain
- X-ray, lab
- We would have been better off with the old hospital and the same level of service rather than the present great facility and lower levels of staff because the money is needed to heat the building
- Rural communities - we are desperately concerned that we can keep what we have, and then move forward to have services that are available in most other places
- Access to services, senior citizens here have a problem because they don't want to ask for travel every time they turn around

- There is no public transportation
- We need
    - Well women's, well men's, well teens
- Mammogram bus comes once every two years to Neil's Harbour
- Developed a satellite clinic south of Smokey before the ferry (had for 3 years)
- St. Ann's Health Project
- Minimal funding ~$30,000
- PATH Project
- Set up to do health centre, begged for money from Eastern Regional Health Board and Community Health Board
- Got ~$15,000 from each board for the setup
- Hit all health issues, prevention, promotion
- Had coordinator, some project presentations
- This should be in every community in Victoria County, $15,000 would save millions, shouldn't always be on the back of volunteers
- Should be able to bring in talkers as necessary
- Clinic has no real home, moves as necessary

- No matter who you talk to, budget cuts, we are lean and mean, we have suffered cuts as corporation, regionalisation
- $150,000 over 2 years, would have to be taken out of this area budgets, this would
- We need to continue the Healthy Community Funds for Community Health Boards
- Palliative care, walking track, dietary library for the satellite clinic
- Youth group to get healthy living information
- Grass roots programs
- We were helping small communities
- We need to maintain this
- Our community health board has no operating budgets
- All CHBs should have funding as in the Western Regional Health Board area
- The government must recognise that the support networks must be in place to keep the volunteers interested and viable
- If we expect to have community health organisations we need to have the financial support in place to make this happen

- Give some consideration to the doctor to decide how long a person must remain in hospital, don't allow the pencil pushers to decide these issues
- Make sure the same standards are applied to everyone, my mother and John Hamm's mother,
- Make sure standards are on basis of merit

- Keep the counts accurate, the counts in rural hospitals get skewed

- 1996 - OP counts - Cheticamp and Baddeck had 200% of population base, Neil's Harbour had 69% of their population because they were doing good triage
- We can put the numbers up if we need to, we get docked for doing a good job
- Doctors are working in the x-ray and lab departments, and jobs are being lost

- Have cross-trained staff, concerned about the quality of service provided by cross-trained staff, when they only have 2 weeks training
- In out patients department, the patient has to be seen within 15 minutes, in ours they aren't even seen by the RN
- In Baddeck we send patients to North Sydney for x-ray because there is no tech on duty, imagine what would happen if we did that here
- With our hospital - we are supposed to be way over budget with nursing, we could send them down to the doctor's office, the ER nurse was being taken out of there
- At least 70% of OPs are being triaged by doctors, this is inappropriate use of physicians
- Decisions are made only on numbers
- Grand computer system doesn't send information into
- No clerical help in the hospital, the nurses are providing clerical work
- This facility had security, this was eliminated, before the union was notified,
- We need security here - told to triage someone through the door, this is ridiculous
- Just 2 female staff members in building
- There is a centre for battered women in the basement, husbands coming looking for wife, drunk, armed, etc, will be dangerous
- 2 women won't be able to cope, RCMP response time might be 1 hour

- 911 call from hospital, RCMP showed up 2 hours later

- 1 janitor looking after 34,000 square ft

- Summer, great place to party, never come alone
- Where are the jobs, we need trained people to do work, what are we paying taxes for
- We are using doctors to run around the building checking
- Where are we going to get the money for essential services

- CSR is staffed by whoever is available, this does not meet the criteria for accreditation
- Accreditation for Buchanan Hospital took 15 minutes
- WHMIS staff was trained by hospital, funds raised by this person doing seminars went to Eastern Regional Health Board
- When the new hospital was built, the budget stayed the same, electricity went from $2,300 to $10,000 within 2 months and the budget was not increased, oil over $100,000 per year, why did they build a new hospital if they were not going to fund it
- When pharmacy is closed, the hospital pharmacy acts as drug store, moneys made here go to Sydney to the global budget
- American patients are still considered money for the local hospital, the others are not any more
- Pay to have qualified staff on full-time staff, decrease the amount of part-time staff
- There are a lot of inconsistencies that are frustrating the rural health care worker
- The staff are part of the community

- Where is the link between feds and provinces in their look at the rural communities, where are we going to get the support we need to maintain out rural communities
- There were recommendations that came out of this
- Loomis Report?

- A lot of words and no action
- NS in terrible financial shape
- We are paying the price for this
- We need to look at our local assets, put a value on it, say to government that

- Local input needs to be put into the budget process while discussing
- The same accounting principles that apply to the parks also should be applied to the local hospitals

- The government needs to realize

- We don't have the health care dollars to care for the people we have now

- More dollars for health education
- Don't cut the budgets for health care education, Heart Smart, Smoking Cessations
- If you develop the services further you will lose the staff from acute care
- Make some incentives to bring staff into these areas
- Add benefits to recruit staff to
- Tell staff the truth, if you are going to bring in staff, give the budget $ to run the facility

- Staff leaving are not being replaced, they know their colleagues are left short-staffed
- Stop the casualization of nurses
- We are losing the nurses to other areas, the only incentive we need to provide to keep our nurses here is a full-time job

- The staff has been cut back so far that it is dysfunctional, staff are not being replaced
- The Eastern Regional Health Board will give back the 7-3 nurse
- OP nurse will be with patients
- If someone calls in sick they will not be replaced if they are not busy
- The system is not fair

- Physician availability is not a crisis yet but it will be soon, the physicians are aging, Inverness will be in crisis soon, they are 65+ already
- Physicians are leaving and aging
- Need to have incentives for physicians, there are some for Inverness but they have no jobs for spouses
- The Department of Health is unilaterally deciding what the GP's can do and not do at the local level
- Administrations are making more and more decisions that were physician decisions before this time

- You need to deliver the same levels of health care and education in all parts of the province
- North of Smokey you only have 1 level of health care and it is total chaos
- Lost neurosurgeon

- We are getting punished for delivering appropriate care

- Casual staff are not available
- EMO proved this, they had an emergency and no one came

- ? Are we going to lose 1 of our ambulances

- You can't look only at the numbers, you need to look at the geography

- 328,000 cars went through the park this year, this is not counting trucks and buses
- No one is listening to us, the MLAs, the Department of Health
- We are being marginalised, people have given up, they think no one will listen
- Have tried to, people are being punished when they speak out, removed building supplies from building, they are being threatened and fired
- Moving things away from here creates a problem, the people in Halifax don't know where places are in rural Nova Scotia

- We already have a 2 tier system - drugs
- We don't recognize the working poor

New Waterford

- Past year father & mother in hospitals, both regional and New Waterford
- A lot of problems in hospitals
- No one wants to listen, nurses think you are AFTER them and don't pass comments on
- We are in a big mess, need to start from scratch
- Meeting different people, too many unions
- Each hospital needs a suggestion box
- Members of family come to her, take our concerns to CEO
- People are afraid to talk out because the hospital will hold it against the family member
- Father on stool softeners and in a diaper, whole floor on these, no need, could save money on this issue

- Too many people stealing things from the hospital, knives. Forks, wheelchairs
- Not a thing wrong with the Waterford Hospital
- Raises 15/1600$ per month for hospital
- Buys beds, O2 tents
- People complaining about getting blood tests, now you get a number
- Stealing band-aids and towels
- Person stole w/c with the nurse watching
- The hospital was downsizing, we are now picking up with pies and raffles, turned around and got the $1 ticket
- $932 the other day for Sobey's slips
- Hard to get people to help out now
- Got 8 electric beds to replace the crank beds
- Don't call down New Waterford hospital

- Can't call down the nurses, they have a union and you can't say things about the nurses

- Lack leadership at the New Waterford Hospital
- Department head retired 4 months after she did, and there was no one in charge or left to lead
- This is prevalent all over the building, all departments
- 3 years ago there were no line ups, the regional has line-ups so people still come here to avoid the lines at the regional
- Lady from Glace Bay told a pt that they couldn't collect today because they were too busy
- Lack of leadership is pervasive

- The leaders have retired, and people are now doing 2 or 3 hospitals, i.e., GB, NW, etc.
- There used to be someone on site 5 days, now only part-time on site
- Head of nursing service is out of Glace Bay
- People on site no longer have the authority

- This is a coal mining town, the mines are being closed and there will be few jobs left
- Funding to raise money for beds, etc., shouldn't be done in the community, the funding should come from the province
- Kids today have no manners, they will close a door in your face, they keep their hats on in church
- The young people need to be taught things
- As a patient in New Waterford
- Patients need to be treated with respect
- Breast surgery patients shouldn't have to be left sitting in waiting room at 102 degrees while the nurses have their smoke break, and left on display, staff saying, Oh is she here again?
- No confidentiality, breast surgery patient had information told outside the hospital by staff who saw her at the out patient department and waiting area
- Waiting area shouldn't be at the front door

- The government was downsizing 3 years ago, and the only reason it wasn't closed was because of the people in the town of New Waterford raising money to save the hospital
- The women on the hospital auxiliary kept the hospital going

- PHC has the power to talk to the government to put more money into HC
- We are short doctors
- Nurses, techs in lab & x-ray are overworked
- We need to see more money and staff going into health care
- CEO needs to be more accessible, we need to be able to see him in our hospitals, the admin needs to be out there and be seen
- There should be a Director of Nursing for each hospital, not both

- New Waterford
- The centres are running very well
- The kids tonight have a concert at the school so they are not here tonight
- Would like to see youth on the health council

- To speak positively about the youth health centres
- 3/4 years in committee level across the area
- A group of people got together to prepare a holistic approach to youth health
- 22 member advisory board
- Centres started, New Waterford was 1st, August 97, don't reduce this service, have BN and doctor coming in
- The centres are fine
- Need some education
- Under the CBHCC, legalities
- Not sure the CBHCC is relaxed enough, need to let the community and the kids get on with things
- CAYAC - 75% of the CAYAC people talking to the youth
- Good way for funding to come about, CAYAC and the Youth Secretariat combined effort
- Kids say they need an adolescent psychiatrist, the service from Halifax is not sufficient, 1.5 weeks ago had a 14 year old boy suicide
- Would like to see a CB Regional Centre for Kids to get help with drugs and alcohol, similar to program in Dartmouth
- Need family support, traveling to Halifax is not great
- Also need help for kids who get in trouble with the law have to be sent to Shelburne or Waterville, need a centre in CB to keep the kids here so families can be involved in their treatment and rehabilitation
- Also involved with Island Justice Society, have a good success rate, repeat offenders are often drug & alcohol related
- Kids don't get the 50% option adults get in serving sentences
- Could be a joint venture for kids with drugs and alcohol as well as get in trouble with the law

- Barriers are not as common at the grassroots level
- Poverty has a great impact on health
- Community services deal with income, health does not
- Need to have reporting to all departments not just health
- What do we need in the community
- Health centres
- Places to get together to talk about how we get and stay healthy
- The workbook doesn't really address these issues
- $ are focused on clinical services, not on education and prevention and promotion
- Not all programs are funded and available across the province
- Illogical funding methodologies
- We do need to, look take a critical look at how departments function, how do we meet the kids needs
- The promotion of health is very important, if we stay healthy we are better off
- Low income people don't need Canada's Food Guide, they need the money to buy the food
- Health looks at one thing, community service looks at something else, they need to talk to each other

- Worked with victim services, they are treated as criminals not victims
- The government is victimizing the people of Nova Scotia

- Let the government people come out here and listen to us directly
- Talking to PHC is no good, we need to talk directly to the government

- Interested in seniors in our health care facilities
- Need to have holistic treatment from the system
- Seniors are heavily medicated, stuck in bed, not fed, we need a holistic approach to care of our family
- Attitude is poor, from training we need a holistic approach
- Interdepartmental communication is a problem in the local home
- People had to meet with the administrator to ask for a complaint form
- Airborne diseases in hospital is a problem
- Smoking staff caring for patients is ridiculous

- Why don't we build buildings with opening windows

- Flu season - should have clinics
- Don't waste the time of the out patient department and the doctors to treat flu
- Where are the well baby clinics gone
- Let's have flu clinics
- Nurse Practitioners
- They do it in Rankin Inlet, why can't we do it here
- Volunteers in this province are burnt out, you see the same faces over and over again
- Government loves this, it costs far less
- Replace all the volunteers with paid staff
- Volunteers don't get thanked

- Concerns about mental health, especially psychogeriatric
- Nothing happening here
- No psychogeriatrician at CBHCC
- Some consultation geared to younger people
- Sever mentally handicapped elderly - where do they live - they are taking up acute care beds and are not properly cared for

- CEO promised adult and child in January, where are they
- CBRHCC recently advertised for psychogeriatric nurse
- Long-term care is geared to wards the well elderly, not the sick
- You could put 350 beds here and they would all be filled tomorrow
- New Waterford has 29 active beds on medical, 18 of them are for placement, Northside has the same problem
- Baby boomers coming, the youth are leaving to find work
- The youth are very discouraged, they are leaving now
- Costs $32 per hour to go to university, you can get a job for $7 and you pay $3 to the government
- This is not a stupid island, but we are very cut off from everywhere
- A lot of CB feeling is defeatist, why do it, no body pays attention

- A lot of depression, drugs, alcohol, petty crime, kids are discouraged

- No child psychiatrist
- Group homes - none available for kids with special needs
- Brass Tacks in GB is filled
- Nothing for schizophrenics outside Sydney (Clubhouse Connections, Bentinck St)
- No public transportation system
- Seniors in town are mostly women, mostly widows, need to pay $3 taxi fare, plus have to pay taxi driver to carry the bags to the door of the building, Sobey is only store in town, terrible
- Local doctor - you have to go first thing in am to register and then come back later for the appointment, costing twice fares, otherwise you have to wait for weeks for appointment
- A lot of people have to go to out patient department as they don't have family doc, therefore emergencies are left waiting in out patient department while doctors see the walk-in patients

- Psychiatric help for elderly
- Poor nutrition leads to mental health illness
- We have parasites here
- Ate poorly, doctors said nothing wrong, doctor harassed her, called her at home, reported to MSI, naturopath told her she was allergic to food additives, family doctor told her it was too expensive to do the test, finally started eating right and cleaning out her body she got better

- Defined licensed doctors
- Out of country doctors that are not completely licensed here, why are there more in CB than elsewhere in province

- Future training of RN, techs, etc.
- There are no classes for lab techs in the province now
- Will become a university course

- We shouldn't have to wait 3 months for a mammogram here
- There is a lot of breast cancer in this area
- There are a lot of people here on estrogen that can cause cancers
- The younger docs are better at telling patients their options, this is important
- There is a natural method of getting estrogen from green vegetables
- How successful are the communities with community health centres
- We need these across the province
- A lot of drug stores are doing clinics
- Picked up a lot of people with elevated cholesterol, etc., we don't have this here
- We have a lot of people going to pain management clinic in North Sydney, Dr. ? has brought in the machine, MSI doesn't cover this treatment, could cost $5 to $700 per course of treatment, doctors tell her it is in her head, turns out to be severed nerves, can't afford it
- MSI won't pay for phototonic imaging
- The government should know about this and look into the people who have pain
- New Waterford has terrible water, by-products of coal mining, also has radon gas, her house has 200 times the limit, called the Department of the Environment, they didn't have any idea what it is

- New Waterford water supply from lake next to dump, fish dying, seagulls in dump and then in the water supply
- Joe Wilcox fighting these problems, people swimming in the water supply, dead horse, cars, transformers, etc., by the lake or in the lake, rail cars dumped coal in the lake, 200 gal oil drum in the centre of the lake, we pay for this water, toilet tank is covered with oil, filled swimming pool with water from town supply, was filled with bugs even the Department of Health couldn't identify
- The water is not fit to drink
- The eels are dying in the lake, you can't even kill an eel in a frying pan
- Buried the houses out there, didn't haul them away
- The government local & province pass it around
- The water eats the brass taps away
- High incidence of kidney problems as a result of the water here
- 4000 names signed to petition to go to Halifax

- Where are all the people from New Waterford?

- There are well women's clinics in this area, why don't we see well men's clinics? Why do they hold them in the day time, why not on weekends, or evenings?

- We need another drug & alcohol counselor, immediately
- Kids know where the drug suppliers are

- No No Smoking signs to be seen anywhere in New Waterford

- They spent $5000 to build smoking hut behind the hospital
- They brought it on themselves

North Sydney

- Beginning to develop a CHB here, now seeking members, March 1st the deadline, trying to reach every area, stretches over a diverse and stretched out area. Board will be in place April 1st

- To have oncology in CB is great. To go to Halifax was disruptive to all the family. CBRHC has full service centre now, paediatric one at IWK and full body radiation is done in Halifax

- The proper usage of the hospitals, especially emergency rooms being used inappropriately. How do we fix the system to be used properly, ER, critical care beds for rehab or long-term care patients. We have enough beds to handle the loads if they were properly used. The system needs to be redesigned for better usage

- We need 24 hour clinics staffed by nurse practitioner for the things that don't need a MD. Sometimes just need reassurance, better human resource management. Better use of LPNs, RN's.

- Ultimately that kind of system will be cheaper, free up doctors so we don't have a shortage, free up critical care beds

- Worked in OP, saw third generation of users / abusers

- Education of people is necessary, but we need an alternative place for the users of op to go. Need user friendly alternatives

- Call line with RN on other end is extremely effective use of resources. To deal with some of the system

- Son in armed forces - on base they have holistic system on base where he works as medical assistant (her son) have outlined protocols - she worked as nurse for DEVCO with same system, her son is very happy with his role (25) he makes decisions, stitches, etc., just back from Turkey, somewhere between a paramedic and a doctor

- I don't know whether I want that decision, unless someone is going to stand behind me, kids can go sour so fast, fearful of suits, no longer have the hospital to stand behind you

- 9 times out of 10 in out patient department I was telling them to come in
- People in North Sydney - short of beds for nursing homes, 1 floor in hospital is all long-term care beds. A couple of rooms in OBS are being used for long-term care. 15 to 20 people on gurneys in out patient department. Day surgery people not quite ready to go home at 5 pm also get sent to out patient department. Long waiting lists for family doctors. (Dr. Paul Hickey). The system will work for an emergency, however

- Did have a problem for a while about 4 years ago but this has eased off somewhat. It was a major problem in Glace Bay but Dr. Naqvi fixed this with his clinic

- The Kiwanis or Kinsman have blood pressure checks within 2 weeks. Many people were walking around with blood pressure of 190/200 (retired nurses)

- The doctors might see nurse practitioners as threat at first but will see the good as time goes on

- Consumers on Northside, only 10 miles from CAT scan, specialists, etc.

- People are waiting in out patient department for 4 to 5 days before they can get into a bed. Common to North Sydney, Glace Bay, New Waterford. Out patient department has become a hospital ward on stretchers. No privacy either, shared washroom, worse in the old Northside General than now

- Also worry about the demographics of the senior population. Long-term care beds filled, teaches home care, need to enhance home care, more acute min CB than the rest of NS because the young people are gone, and elderly are moving back home to retire, we are not ready now and won't be ready anytime soon. The resources don't match what is out there now. We need a plan in place now for the next 20 years

- Mother elderly sick, well cared for by her second husband Tom, both 78 years old

- Taking care of your own family members is fine if you can but how are we going to cope with all the baby boomers as they age? It is a different world today than in our parents' day. We have exported our own children too to find jobs

- We should be training PCW and home care workers in the same classes

- Other fear - growing addiction problem in NS, including addiction to gambling. Seniors are losing their cheques and their homes, need resources, phone lines, seniors are wearing Depends at casino so they don't have to leave the machines. Also serving liquor at the places where gambling machines are placed

- Still serving cigarettes to minors young as 12, drug stores are no longer selling cigarettes in store but all have built outside entrance to part of the store to sell cigarettes

- Strongest abuse of seniors here is financial abuse because they keep it under the mattress

- Chemical spill on the weekend - North Sydney. Saturday, EMO was well prepared for this, hats off to them

- Ambulance service pretty good, improving since government took it over, 911 works very well. Horror stories 7 to 8 years ago, but much better now

- Marine Atlantic deserves full credit - have put automated defibs on all gulf crossings boats. And have the people trained to use them

- Smoking - great discussion about smoking

- Dental problems, some are necessary to save your teeth, medically necessary but still not covered by MSI

- Moles suspicious removed

- There needs to be more emphasis on education and prevention

- Foot care has to be paid for, should be covered, prevention again, should be covered

- Toenails - need to be cared for - good walking or you put such a stain on her hips and back

Pictou

Responses to "What does it mean to you to have a healthy community?"

- Enough medical personnel to help the sick
- Healthy family: emotionally and physically
- Economically stable community
- Health for all aspects of each person
- Ambulance services: which knows civic numbers and the geographic area
- Various accessible services: people know about them, they are accessible (e.g., sliding scale fees, accessible buildings, transportation)
- A facility that provides necessary health care when its needed
- Communities that promote recreation for all ages
- A lot of people are hungry: if we have a healthy community, we take responsibility for helping those in need without victimizing them
- No one in poverty, no one homeless
- Emphasis on importance of children staying well: emotionally, physically, good nutrition at early stages of development
- Easy access to advice about self-care (able to phone someone and get information and advice)
- Everyone can have a doctor
- Proactive programs and services instead of reactive: outreach (parenting, mental health, addiction issues, old people issues)
- A community that has a the ability to care for each others needs (community centre, various assets)
- Supporting services in the community for learning healthy lifestyles; fund raising for learning programs
- Helping parents support wellness at home
- A place where you feel safe and secure
- We generate services ourselves with government support
- With gambling (doesn't encourage addictions)
- Healthy physical environment (air, water, food)

Responses to: "What services do you need to support a healthy community?"

- We need to be more closely connected with government and government with us. Much discussion around whether the government listens; one woman brought forward 4 reports done by groups in Pictou West focusing specifically on health needs for Pictou. Many of the same issues are expressed in them as at this meeting
- Some kind of 24 - hour service with a variety of professionals (not completely dependent on doctors) such as nurse practitioners, nutritionist, mental health worker
- Services for youth (a questionnaire done through the high schools is being distributed and used for planning purposes)
- A fully staffed hospital with beds
- Home care
- More resources in mental health will reduce other problems

- More drug education for youth in schools
- Ensure that we have quality assurance of services and programs (consumers involved)
- Good network of community communication to stay well
- Stop cutting programs like home economics, family studies and woodworking
- Day care for the elderly (including those with Alzheimers, physical and mental disabilities) to provide for social interaction, activity and treatment where needed, respite for care givers
- Capacity-building to best care for our own needs
- Stop cutting funding to needed existing services
- Ensuring that services like "Open Door" (for the mentally ill) and "Planned Parenthood" and "Kids First" (family resource centre) keep being funded
- Expand on health promotion and illness prevention
- Transportation
- Psychiatric services reasonably available (timely, reasonably close to the community, e.g., at the Aberdeen)
- Support for the mentally ill be integrated into the community
- Community wellness centres: some is an integration of what we're already doing – need less fragmentation and more collaboration
- Support to keep elderly in home longer
- Good home care including palliative care

Some Principles put forward and Some General Comments

- Core services do not necessarily have to be provided by government
- Government needs to support communities as they provide for themselves
- We've lost a lot and nothing replaces it. We need to look at this and see what we need
- Adequate beds is not people in the corridors for two days with no place to be admitted
- There's something wrong if we're so afraid to being sick
- Balance, prevention and treatment
- We have to do our work differently: we spend a lot of time on administration
- We need good solid training for home care workers including practical work experience
- Shorter gaps between diagnosis and treatment - cancer care, surgery, heart, hip and knee
- More support and advocacy to guide people through the system
- Shorter waits for specialists
- Variety of specialists come to the community
- Mobile breast screening
- More $s in mental health care, especially community-based. Qualified nursing care
- Prevention and education measures
- Open local hospital beds that are less expensive than the regional hospital beds
- Shorter wait times for emergency care
- Quicker travel times to emergency
- Concerned about early discharge with no home support
- There's a lot of good in this country. We need to support what's already working
- Administration of health system
    - needs to be supportive of good care, not obstructive
    - need to use the brains of the front-line workers (nurses, etc) and community
- "We need to be *listened* to"

- We need to cure the cynicism that's there as a result of not being listened to.
- We need to wisely spend the $s we have.
- More front line nurses, in full time jobs, not casual.
- Volunteers are getting burnt out
    - Too much is now expected of them (they are even being told what to do on their own time and at their own expense) e.g. fire fighters as first responders.
- We need a model for community based services; one that decreases reliance and dependence on the system and increases self-responsibility for health
- Our health care system has become a joke.

Sackville

- Biology - genetic endowment
- Medical information with families
- MacLean's Magazine
- Two cancers - skin - melanoma, colon,
- Tracking individuals with melanomas
- Family tracking of moles
- Things that affect your health
    - A lot of people can't be bothered
    - Fast food
        - Chips with gravy at 10 a.m.
    - People don't understand
- Genetic Counseling
- Difficult teaching
    - But needs to be done early to save the system money

- Workforce
- High percentage of young adults working for minimum wage, many hours
- No medical coverage
- We help some low income segments and we need to support others, especially working poor
- Drugs are very expensive
- Rec drop in clinics, especially rural areas
- RN's can handle many of the easy stuff that doesn't require the expertise of physician (minor stuff)
- The days are gone
- We should all be treated the same

- Reaching the limits of health prevention and illness prevention
- Increased chronic diseases
- We need to start earlier with education - into the school systems
- Benefits/economics
    - Stress - MI
    - Need control of working environments
- UK/Holland - benefits set up the same for everyone. Also in Iceland

- Health care today is falling out of the realm of traditional medicare. Need to address these elsewhere - school
- Food choices very important

- Iceland - cradle to grave coverage
- Going to study Icelanders to see why they are so healthy

- You have to prevent disease to lower utilization of resources
- Health promotion and education
- Look at promotion, not only as preventing first event, but also how to prevent a second event (i.e., MI)
- Government needs to build partnerships with NGO's to develop promotion and prevention

- We have never had health care system, we have always had illness care
- Need to start from birth
- Now trying to turn our heads around to wellness
- Need to take responsibility for our own health
- Need good, accurate, up to date information to make appropriate choices
- Lunch and learn at Sackville Library

- With chronic disease you won't see improvement for 50 years

- Politicians don't last 50 years
- Focused on short term/not long term (4 years)

- Health charities network
- Need government to recognize the contribution the NGO's make
- Heart and Stroke Foundation
    - Wants CPR training in schools
    - More than pump and blow
    - Risk factors, S&S
- Nutrition programs for kids
    - Don't sell Popsicle's, chips, pop
    - Sell applies, bananas, etc.
    - i.e., practice what they preach
- Health programs and phys ed programs are being cut
    - This is not healthy

- Sackville has lots of recreational facilities
    - Fields
    - Sports stadium
    - Fitness centre
- Doubling size of fitness centres
    - Will have curling rink
- Shy of passive - i.e., walking trails
- Do have 700 acres with Second Lake - partnering with Nova Scotia Government to develop

- We often adopt healthy life style after we are ill
- Many back sliders
- We are not doing a good job at this
- Also have Cobequid Multi Service Centre. Very spoiled because we have this
- Model for rest of Nova Scotia
- Will be replaced and services expanded
- Needs another long-term care facility for Cobequid area
- Population is aging, although still younger than rest of HRM
- We need to invest in healthy life styles
- Too many people don't have health care insurance to cover necessary meds, etc.
- Compared to Labrador - we are well served

- Thank him about walking trails
- People indicated they wanted this
- Developing one from Sackville to Bedford
- Major issue - transportation
    - Stress in accessing services
- Fall River - no public transportation
- List of stuff in Cobequid Multi Service Centre
- Rebuild Cobequid site - is a unique opportunity for a model ____ than be copied elsewhere
- Need partnerships
- Dump turf wars
- Newfoundland - health and social services are combined
- Need information - health - better health
- 2003 - it should be opened

- Disability - if you are looking at this, I have scoliosis, Kyphosus, spine, etc. - need to look at driver education
- Legislation pending re: driving with doing other things - e.g., lipstick
- Reaching first goal is problematic
- Disability
    - Physio can ameliorate some

- People are living longer with disabilities
- Father was Mayor of Halifax in the 70's - now in Ottawa
- Foundations - volunteer money raiser

- What we are identifying now has been around 30 years
- Marc Lalonde - 1974
- Better educate people through their family doctors
- Family doctors don't have time - will have quantity system not quality system
- Start right away
    - Bring in nurse practitioner
    - Put doctors on salary

- The partnerships are important

- We need to look at how doctors are paid
- Look at nurses, not just practitioners
- You don't need the deity

- First line staff are part of the solution

- They need the time, not just the ability

- Health goals are great
- We need strategies as to how we can achieve these
- Would be nice to have outcomes

- Psychological benefits of passive recreation
- Potential for passive recreation is also important
- Critical focus of health care services - more forward together with Parks and Recreation
- Need to look forward when planning
    - Keep politics out of placement of Cobequid Multi Service Centre
    - Growing outward, place centre where the community will be in 25 years, not where it is now. Judy and Joy are on committee - assure that it will be appropriate for 25 years down the road

- There will be public consultation around site
- Cobequid people need to get out and speak

- Will have green space around it for recreation
- We lost a lot when we lost well baby clinics
- When we closed rural post offices, we lost the neighbourhood watch - the post master always knew when an elderly person wasn't seen for several days

- 90 year old mother placed in nursing home with dementia
- Not enough staff with training to care for our family
- Lack of wheelchair access to tables in long-term care (Shannex)
- Mom went from 105 lbs to 84 lbs - wheelchair couldn't get into table and dropped food in her lap
- Need more RN's
- PCW training course is inadequate
- Independence is taken away very quickly because the staff rush her
- Private ones are cutting corners on the backs of our seniors
- One woman left in wheelchair 5 hours - loss of dignity
    - Not being assessed regularly or properly
- Family are afraid to speak up because they fear repercussions on their family members
- Department of Health inspection of long-term care facilities are inadequate for private for profit facilities
- Department of Health Should ensure the safety of residents
- The home is blended care - one dementia patient beat another woman over the head with her cane

- They knotted her mother's knee highs
- Hair unkempt
- Nails dirty
    - She had to fight with them
- Staff shortages
- Newfoundland has no PCW's, all LPN's
- Long-term care patients are voiceless basically
- Department of Health - should be Family Council - resident's council is a farce
    - Owners won't listen
    - Management team is subservient to owners
- Department of Health visit seldom
    - Should have an investigator

- There needs to be planning
- Not a political football
- Need to re-examine the long-term care bed need
- We have hit the financial crunch but the bubble hasn't hit the seniors yet
- Process should be streamlined
- Shouldn't be because politician is involved

- We need coordinated home care system
- Acute/long-term care situation needs to be clear and not politically controlled
- When they planned a facility

- Halifax will experience a shortage of single level dwellings for seniors soon

- Home support needs to be enhanced so we don't fail as fast

- Maybe Cobequid should look at Northwood model
- His dad is medical doctor with office in Northwood
- They are expanding

- Numerous conferences on ____ requirements
- CPC
- HDRD
- CMHC
- Housing
    - Too many conferences and no action

Fixed budgets
- Alan Rock

Shelburne

- Health goals - role of community hospital to be preserved
    - Bed, outpatient/Emergency/restore day surgery

- SRAC to remain intact
  - Diagnostic services to remain in Roseway
- Community Health Board
  - home care, long-term care, residential care
  - Demand increased supply of those services
  - Concern re: private enterprise
  - Health promotion, illness prevention - lack of financial support - if government is serious put money where mouth is
- Drug abuse - problem in Shelburne
  - Addiction services should be maintained and enhanced
- Mental health services - 330 new cases, 2169 visits
  - Maintain and increase capacity
- Public health services
  - Enhancement
  - Non-communicable disease
  - Prevention of illness and infections
  - Keep and enhance resources already there
- New DHA - Shelburne, Digby, Yarmouth - need equal representation to maintain equality
- Some stats

- You are not the enemy
- Thanks for listening to input from various communities
- Roseway Hospital - we expect the present services to remain and to return to its original state of service
- Need to look at geography
- Need to build responsive system, need to put Community Health Board to work
- Shouldn't store Roseway's supplies in Yarmouth
- Shelburne County has beautiful building. We have watched our services decline
- Please restore to previous level of service

- People want to retain hospital
- People want to increase services as community determines
- Shortage of family doctors - especially in Western Region and Lockeport
- Well known to Department of Health and Provincial Government
- Is the provincial government prepared to fund a viable community hospital in Shelburne
- Is the provincial government prepared to sit down with the federal government to negotiate the barriers to immigration of doctors to provide services to such areas as Barrington and Lockeport

- We missed psychiatry in workbook
- 1992 less than 1 full-time mental health worker for adults
- 1992 less than .5 full-time mental health worker for children
- Since regionalization 2 full-time mental health workers for adults
- 1 full-time mental health worker for children
- 1 full-time support worker for each
- Very concerned that move to DHA will decrease mental health services
- Three counties don't have access to child psychiatrist
- Very big need for adult psychiatrist

- Regionalization led to increased autonomy of staff
    - Developed good partnerships
    - Self-help groups have been developed
    - Good public relations now as a result of more autonomy
    - Fearful of control by Yarmouth

- Lack of psychiatrists now
    - One left providing one day per week
    - Short in Yarmouth and Digby
- Politics of psychiatry is confusing
- Access to service - also transport to the service if it is not available in the community
- People with little money who can't afford drugs - little cost now leading to greater cost later
- Abysmal lack of opportunities and facilities for people to achieve and maintain health, e.g., rinks, swimming pools, etc.

- Family doctor in Shelburne
- Lack of family doctors, were 10 5 years ago

    Barrington requires 24 hour coverage

    Shelburne requires 24 hour coverage

    Lockeport has some coverage from a semi-retired physician
- Were no waiting periods
    - Down to eight family doctors
    - Emergency service in Barrington now less than 24 hours, seven days a week
- Has increased workload in Shelburne leading to doctors must now be in hospital, leading to less office time, leading to frustration and longer waiting times for appointments
- Physicians now in react mode to crisis
- Spiraling effects of shortages are being felt by doctors, nurses, patients
- Need to look beyond the immediate problem
- Family doctors are in mid 40's with families, looking forward to retirement but there are no replacements available
- One more physician loss may lead to crisis situation
- Barrington should have 24 hour coverage - government needs to look at this

- Shelburne County Youth and Health Support Centre
- Executive Director
- Advocates on behalf of youth
- Now have centre - across from high school
- Mandate to service more youth from 17-18 years for county
- Building and funds to support one full-time and one part-time staff member and some operating funds
- Doctor left money (Shelburne native) for this service
- Over 1,000 young people in the county
    - Surveys in three high schools were carried out
    - Young value their health
    - Some ideas to assist youth maintaining health
        - Nutrition

        - Addictions
        - Abuse services
        - Relationships - family, sexual
        - Confidentiality
    - Deliver services
    - Critical to keep hospital, nutrition services, physiotherapist, addiction services
    - Youth centre propose referral
    - Youth centre propose counseling
    - The problem is money to provide the services
    - Will be working with Community Health Board to develop long term plan
    - We can reach our goal (primary health care model)
        - Need to spend money now for future savings
    - Have short term goals - will be working on long term plan later this month (Dale Ryer leading process)

- Has not prepared submission and will mail it to us

- At Liverpool on Monday night
- Interested in one comment by mayor - eastern part of Shelburne County will be included in DHA 1
- Community Health Board defined borders as county going to be turf wars
- Queens wants to add eastern half of Shelburne County
- Queens presenting solid front of district/staff/councilors
- See overheads
- Shelburne has a population of more than 17,000 population versus Queens 13,000
- More traveling to Yarmouth
- Less traveling to Queens
- Taking family members and either stay or go causes financial hardship on families and individuals
- Disease prevention - health promotion
    - Community Health Board sponsored strategic planning session
    - Paper submitted
        - Summary - biggest issue was ownership of hospital, second was OBS and surgery in RGH
        - Local decision making
        - Look at comparison Queens/Shelburne
- 1990 - role of study - RGH - primary hospital facilities
    - People of Shelburne County
    - Looking at primary care
        - General medicine
        - General surgery
        - General pediatrics
        - General OBS
        - Diagnostic services
- Budget comparison
- Queens hospital plan

- Submitted in writing

- We do not want to divide our county
- Queens Community Health Board was told this and apparently not listening
- Shelburne is not interested in becoming part of Queens County or Shelburne County

- 700 people in Lockeport. Town of Lockeport still owns Roseway Hospital - has title.
- Council is adamant they will have their fully functioning hospital back
- PHC didn't meet with municipalities (our oversight)
- Mayor has asked MLA to arrange meeting with Jamie Muir for next week
- Lockeport won't be hauled away
- Five municipal units will stay in Shelburne County
- The Deputy Minister does not own Roseway General Hospital
- Equipment has been sent out without permission
- Lockeport has 66 medical calls answered by the fire department - bill for $25,000 being submitted to provincial government
- Provincial government owes $200,000 to Lockeport for hospital and other monies for services, etc.
- No emergency medical service in Lockeport
- One doctor - works 30-35 hours a week
- Lockport - island
    - If beach breached, one provider only available
- Government has done nothing but promise
- Will meet next week and will get answers
- Shelburne unemployment rate is 19%
- Can't afford to travel 1 ½ hours
- Can't be born in Shelburne County anymore, only in Yarmouth, Bridgewater or on the road
- 700 people

- A lot of changes (no need to be afraid of change)
- A lot of poor decision making by government
- Previous government in its transition process - took away services piecemeal
- Roseway Hospital gave up surgery/OBS - given up voluntarily
    - Need to retain appropriate inpatient services
    - Day surgery
    - Consultation/minor procedures, etc. can be provided here
    - Have had internal medicine from Queens County 14 years
    - Have had surgery services from Yarmouth
    - Queens did provide services here on-site
- Shouldn't have turf war
- Queens should be commended on the quality of their care they provide
- We want to maintain services we have
    - Referral patterns will not change

- Need to make sure money follows patient
- Need to keep the good things regionalization gave us
- Much of Shelburne doesn't want to go to Yarmouth
- Shelburne County needs to access as much within the county as possible
- Needs basic services here
- Reasonable volume of service would be possible with sufficient equipment
- New possibilities - plastic surgery, etc.
- Recently - gastroscopy services were re-introduced
- Need stress testing equipment on site - Queens now does this with same internist who comes to Roseway
- What services can we add to support staying in our community
- Need to keep on-site services, don't necessarily involve additional beds
- Need to keep what we have now

- The community isn't an entity. The western end already goes to Yarmouth
- Need to recruit doctors for western and Barrington to re-introduce referral patterns from west to Shelburne
- If Liverpool loses so do we
- Let's be reasonable here. 30,000 people in 2 counties is still less than a large town
- Remove ambulance user fees. This is a discriminatory practice against rural population
- People want to go to QEII - not Roseway - you can't go back to the way things were

- Clinic - off-site services
- Have become very creative at the services we provide as a result of cuts

- Role studies of Yarmouth, Digby, Queens, Roseway
- We are seeing doctors, hospitals - they call the shots
- Look at the spreadsheets to see travel patterns. This tells you what the people are saying
- Look at petitions and letters supporting services here - fire fighters/ambulance, etc.
- Take the factual information - from PHC, Department of Health, Western Regional Health Board to have all those things done

- Blood clinic in Lockeport is in mayor's office

- Physiotherapist at Roseway Hospital for 19 years
- Embrace change
- The doctors aren't even employed by the hospital
- The general surgeon is a dinosaur
- Need to access specialist services for major problems
- Travel patterns are to Bridgewater and Halifax
- As a consumer/health care provider - am extremely proud of what Roseway has become
- Looking at determinants of health
    - What we have heard tonight is Roseway Hospital. The hospital has a long history of going out into the community and asking them what they need (not want)
    - Regionalization provided back-up for her as a single practitioner in Shelburne
    - We do have strong ties with Queens. We shouldn't get into turf war with them

- Needs to look at what our needs here
    - Palliative care/VON/Health Care Nova Scotia needs to be maintained
    - Have problem with access to oncology service - lost Yarmouth service
    - Long-term care beds are needed here. Roseway Hospital has from 6-10 people waiting placement
    - The baby boomers are coming

- Recognize Queens provides services
- Why did government put Shelburne with Yarmouth
- Two options of DHAs are tri-county/or divide Shelburne
- Lack of employment big problem leading to addiction and family violence
- Fishing decreasing
- Bases closed
- Too many regulations for private enterprise to thrive
- Need to have more employment
- Losing hospital would lead to companies not locating here
- Transportation a problem

- Develop programs to increase community health
- There is a lack of services for victims of family violence in Shelburne County
- Department of Justice (Zero Tolerance Program) - programs started a number of years ago. The program has been threatened with closure - i.e., last April surviving on three month extensions to their budget (through Justice and Community Services)
- Excellent resource but need long-term funding commitment
- If it ends it will be very sad
- Need to have this program continued and enhanced
- The alternative proposed is a co-ordinator for several counties, which would be problematic with long-distance counseling

- Access a problem
- Need transportation
- Need access to medications
- Transition process - talks about logical decision making processes (Victor's mythical hospital)
- Primary health care is community based - can't be set up elsewhere - must be in community - and not centralized (palliative, public health, mental health, addiction services, restorative care)
- Addictions services are desperately needed as there are major problems in Shelburne County
- Need services for male perpetrators of family violence - nothing in western Nova Scotia, five programs elsewhere in Nova Scotia
- Determinants
    - Supported living environments - there aren't any within the county. There are no small options available. No residential services for developmental disabled, mental health problems

- Question re: using resources wisely
- Two disturbing trends

1. Decreasing budgets, especially for areas such as professional development/travel less/professional support (lack of support for health care workers), less care, increasing disability
2. USA - HMO - hiring lesser and lesser qualified people to do jobs leading to increased stress in people doing work they aren't trained for and increased stress in the qualified workers (less numbers)

- Will fight to keep Roseway. Three reasons:
  1. Economic renewal
  2. People get better faster in own hospital, caring, close to home and support
  3. Lack of services locally - people can't travel for services, or won't travel
- Health care - doesn't have anyone at the helm
- Many good things happen by accident now
- No plan to address changes
- Keep seniors in their homes - home support needed
- No grand design - it happens by accident
- Anxious about the future of health care - maybe by accident things will get good but there doesn't seem to be a grand plan

- Was in Digby County before
- Fortunate to be housed in Roseway Hospital - visible to acute care and long-term care and physicians in county
- Good communication
- VON now in county - acute home care
- Home support workers help to keep seniors in their homes
- They have a 1-800 number with 24 hour response
- Home care is strong in Shelburne County

- Long-term care and acute care usage in Roseway Hospital - very dangerous

- Numbers are not necessarily reflective of reality
- Need to have beds available for acute care
- Also need to use beds appropriately

- No long-term facility in Barrington, Port LaTour, etc.
- Have to be shipped out of western part of county
- Land was purchased for long-term care facility in Bayside

Workbook

- Needs clarity

- Read future directions
- Alarm bells rang - appendix shows commitment to reasonable access to appropriate services
- Need to be aware of what is reasonable in Halifax may not be reasonable in Shelburne

Government - when it changes - shouldn't all change

Strait-Richmond

- 31 years a nurse, diabetes
- promotion and improvement of health
- environment
- management
- healthy living

Diabetes

- disease with no cure

$6B annually used to treat

- diabetes management centres across the province
- improve quality of life
- seen by specialists
- diabetes is under endo in the book and should be separate
- children are not admitted unless very ill
- seen right away by DEC
- insulin started on OP basis
- 1994 - $250-850 per day
- were admitted for up to 10 days
- referral rates 1993 to 1999 - ERHB 4.35/1000 StRich 3.1/1000
- USA 2.24/1000
- CDA - by 2004 - 1/4 people over 45 will have diabetes

- the education centres and education and promotion save money by not admitting the patients, but the money is not redirected back to the DEC

Environment

- disposal of sharps is a problem, putting into the land disposal
- our area - pharmacy has solution

Income & Social Status

- also applies to diabetics
- treatment of diabetes is very costly and health suffers as a result

- very happy to have PHC members here
- present a document from St-Richmond Hospital staff and residents
- all services listed are essential, but where they are and how they will be funded requires a debate
- promotion, prevention, etc need to be in local community
- free from bureaucratic red tape
- accessible
- need financial resources to support the service without compromising quality
- we must maintain what we have and enlarge the services
- palliative care is exemplary
- rehab services earmarked by the ERHB as priority

- we don't have the resources here, limited number
- MHS are a priority and services are lacking in the community
- 33rd review on MHS in the last few years
- we don't need another review, we need the service
- DEC operated 3/5 time
- sometimes on Friday a new diabetic is admitted to hospital although they shouldn't
- professionally run foot clinics, run 1 day per week in house and 4 days per week outside the walls
- quantifying is difficult
- good health care is education and education keeps you out of hospital
- gnye screening clinic newest venture
- RN's doing screening and overwhelming success
- cancer of the cervix is major problem
- pilot project ends March 2000
- presently 2 OPD nurses are going out to do this
- we don't have the resources to continue this after the money ends
- we need well men's clinic
- CHF, asthma, etc, needed clinics, this is a long term solution
- telehealth opens up new avenues of care
- we use these for ortho, etc
- last week - screening for family violence - we need the resources to allow this to happen in the OPD to make it effective for the community
- how is this going to play out, who will do the screening, RN/Doc do you have the staff, and time to do the necessary work-up on identified individuals
- we need partners in this venture with comm serv & just
- you can't cut the emergency services to provide the other areas of service in the health care system
- we need to maintain the services we currently provide
- palliative care, this afternoon the patient walked in the door with a box of chocolates, the role of the community hospital;
- we need to maintain what we have and expand our community services
- we cannot download any more work onto the present staff and the community
- during the slash we lost docs, the work was not lost

- L'Ordois Clinic, Kingston Clinic, 1977
- see submission

- the Health Project has been doing for the last 7 years what this government says it wants to do
- the PHC should hold this up `as a model for other areas and for further funding

- imperative to continue its endeavor
- continued funding is uncertain and funding may end this year
- we don't want things new, just continue with what you are doing

- working full time in Sydney
- commend St Richmond

- what is OT
    - there is lack of service in this area
    - provides service for problems
    - we are concerned with rehab, leisure, productivity
    - client centered approach addressing all determinants
- working in all environments, schools, hospital, prisons, comm, MHS,
  - OT is known to hold dedication to home care, improving quality of life
  - work within the health goals
  - concerns
- current hospital based service is not adequately balanced
- St M in Anti provides regional service, regular visits to St Rich don't exist
    - Cheticamp, Inverness, Baddeck, Neil's Harbour well served
    - lack of education about OT in the community
    - they don't know about it
  - existing hospital based OT are facing cutbacks, speech therapy & physio also facing cuts
  - need to shift to comm based services
  - St Rich people asking for services are not receiving the services they need unless there is outside pay
- all other provinces currently have publicly funded community based services
- NS is the only province lacking OT services in Home Care

  - request PHC to integrate OT services in the plan
  - there need to be an OT on the provincial advisory committee of PHC
  - compiled some info to leave with George Kyte

  - summary available

  - St Rich Palliative Care Society
  - volunteers about 13 years, 6 structured
  - society formed in reaction to the cutbacks identified earlier
- program proposal for S-R 3 years ago to the ERHB
  - have FT nurse coordinator, Nancy Cameron
  - was PT earlier with nurse here in hospital
  - Recommends
    - consistent with WHO & CDN Pall Car Assoc.
      - coordinated continuous plan of care from admission to bereavement with active promotion and support for pall care through all levels to ease transition of levels and continuity of care
- pursue these goals by making Pall Care a core service, not an optional program to called upon as a last resort when medical care fails
- S-R to implement an integrated interdisciplinary community palliative care program,
  - based on aims and obj

a - to promote & provide quality care to term ill persons (persons living with life threatening illness)

b - to coordinate delivery of such services through a coordinator, pastor care

additional objectives
  - specific needs of soc & prog
    - to develop a structured programme,
    - need RN coordinator & administrator
    - need 3 beds for 24 hour care
    - needs assessment needed
    - planning & provision
    - volunteer recruitment & training
    - education prog for public. Patients, etc
    - funding, evaluation & research are necessary

- hospital based
  - integrated service
  - need space for coord & registry, meetings, etc

- this prog continues to operate, 20 to 30 patients involved in prog
  - 50 admissions since last April
  - 46 deaths and 6 discharges from the programme
  - 1 FT professional plus volunteers
  - this prog needs recognition in Halifax and we need the support and funding to promote the prog

  - thank the PHC for even mentioning in core
- still funded as direct prog of Department of Health
  - don't fall under jurisdiction of CHB or `local facilities
  - prov speech to school & adults, audiology services
  - always within budget, have not been hit with cuts, however the services have eroded
  - senior pop growing, referrals going up,
  - value dollar drop and we have to but American
  - 16 years, services eroded and need growing
  - need to replace 20 year old equip being kept together with masking tape
  - pre-school initiative - a number of years
- we are falling behind other provinces, eg 1 to 1500 students, here 1 to 3000 students
  - the clinic at S-R only one on this end of the island
  - can not offer community based service as he is the only one here
  - sometimes people complain beyond him
  - waiting lists, up to 2 years for kids before they start school
  - how do you quantify the services
  - can put $ values on some services
  - really can't quantify a child's success or lack of in school
  - as in other service areas, we don't need another study to see what needs to be done, we just need the support to do what we already know

  - no money available for pall care, presented to educational board of ERHB and decided
  - regions get 23% of health budget

- did get behind Pall Care to set up 9 programs in small comm hospital
  - some have FT (4) the rest have .5 nurse
  - prog is bare bones
  - most coordinators in rural areas of eastern region
  - death arrives for all of us, we want to make the death a good death for the individual and the family
  - in rural area it is difficult to travel to look for help, you need to have this programme in the community, not at the regional level
  - we have done a pilot project in palliative care and we would like to have recognition for it
  - I don't like the booklet
  - disturbed to have the Regional Director of ERHB refer to this prog as a maverick prog
  - the prog is sustainable as it is,
  - LTC beds and Home Care
  - Transition Plan does not indicate when integration will occur
  - we need integration before single access
- we need more beds, just look mat the beds in small acute hospital
  - treatment of the LTC sector is not equal in nature
- Department of Health in no hurry to integrate these services
  - last year 230 bureaucrats administering the HC prog, these are not the people delivering the care
  - the care in HC is not client oriented

- a dietician at hospital 20 years
  - concerned about dieticians at every facility, taking on more & more duties, but unable to supply the dietician care
  - in charge of housekeeping, laundry, plant operations, dietetics, and others
  - nutrition is so important to our children
  - the dietician services are being eroded, there is no time for the dietician to go to schools to talk to kids
  - one prov person covers Anti, Guys, Inverness & Richmond Co, position not filled for 2 years
  - nutrition support for HC - a great opportunity
  - palliative care needs dietician service
  - cardiac teaching, missing the boat as we don't have the support and time
  - dietician services take second place to all other administrative duties

  - a retired volunteer
- 15 years on the governance side
  - money!!!!
  - PHC say to government we need money for transition funding
  - if we don't see this government sustain these kinds of projects going from 4 to 9 boards will put all the money into inappropriate places

  - I hear wellness & prevention
- this message must go back to the government that we are interested in wellness

  - rumor in Ile Madame we are losing 2 docs, leaving us with 1 doc
- if we are going to stay well we need education programs
  - we need better highways
  - we need places for exercise and walking
  - programmes are too far away from everyone, we need prevention and promotion programmes in every community
- if the government would pay attention to all the reams of material already prepared and get on with it we wouldn't need to be here tonight
- volunteers save money for the government
  - many people are still in their own homes because of volunteers, several years ago he would have been in St. Martha's, look at the money we are saving the system as well as contributing to quality of life, as well as keeping people off the highways
  - it is time to walk the talk

  - 4 pilot projects with Nursing Practitioners
  - the project has begun
  - they play a pivotal role in all other provinces
- RNANS did all the ground work and took it to the government
  - make these pilot projects reality and spread them around the province
- this will save the government money

  - St Peters, retired from the clergy and the provincial civil service
  - in both roles had ample time to be cheesed off by bureaucratic bungling and political posturing
  - one wonderful thing about Health system emerging is that there is room for the volunteers
  - we have the Rankin 4H Camp in Richmond Co, the Minister of Agriculture came down for photo op and he asked one of the kids at camp how he spent his day, posed for photos, didn't listen to the kid
  - the health care system must be as closely related to the people who pay for and own the system, not away
  - 30 years working with addiction services
- Sydney was a pilot project 30 years ago
  - was sect of S-R medical society in the 70s
  - in the 70s we had no dentist, 3 docs, that was all
  - this area has been since the 70s taking control of their own health, working in the community
  - addiction services - Marvin Berth (departed) based on volunteers and intersectoral cooperation and community
  - it also has a prevention component
  - concerns
    - recognise the continuing need for addiction services
    - drugs, alcohol, gambling
    - mental health services need a higher priority in this area than they have had, the services need to be continue separate from addiction services, we don't need psychiatrists interfering in addiction services

- addictions are not necessarily mentally ill, the treatments are very different
- don't create more bureaucracy, Boards Advisory for MHS and Addictions must be broad based and also include the consumers of the service and their dependents

- Married to local physician on call tonight
- Welcome to the new industrial CB
- There is a lot of industry here and getting more., CB Co should be the Sydneys, not industrial CB
- oil transfer terminal, not if but when we have a major oil spill here
- had a recent fatality on the barge
- coal fired without scrubbers for many years
- asthma is bad here, it is not the mill, it is a highly polluted coal burning areas
- the Dept of the Environment is hopeless
- more industry coming here
- Port Hawksbury is never heard from
- the Richmond people are the activists
- we will miss that this is not only a rural area but is also an industrial area, massive industry in Port Hawkesbury, Point Tupper, Ile Madame
- yes we have heard tremendous stories about the services provided but the matrix of this society is the hospital, we need hospital, we need emergency dept, this is a growth area, when you reform the system and we hear that the hospital is a dirty word I get scared, this place is important and if I hear that anyone is thinking about drawing a blue line through this place I will go down and start swinging.
- don't even think about closing this place down, all the other things couldn't happen without it

- Port Hawkesbury is well represented here tonight

- Local chapter of RNANS
- level of volunteerism is good, extremely important to have them in the decline of the health care system because there are not enough staff to go around
- couple of days ago, received package from RNANS, in the year 2000, over 1000 nurses will be eligible for retirement, age 55 to 65, average age is 47 in NS
- we need to step up efforts to recruit and retain nurses
- support the efforts related to nurse practitioners - we don't need pilot projects to show the benefits of nurse practitioners, we have a stack of paper to the ceiling
- we need the legislation in place, in the Medical Act and in the Pharmacy Act in order for this to work
- it doesn't seem that there is a political will to do anything about this at all

- West Bay
- there a great many seasonal people who come and utilize the facilities here, you need to look at this population
- we would be remiss if we did not identify the services we receive here are wonderful, there is an interdependence of other areas of the province, personal face - St. Martha's tells you

there is a waiting list of a year for MRI, have to be at St. M, at 7 in am and you appear they tell you to go home because the tech didn't show up today and we can't help you

- many women of Celtic origin prone to osteoporosis, 2 bone densitometers in NS and none in CB
- care and compassion in S-R is great and compensates for lack of services
- look at load of cancer in CB, we have to travel to Halifax for oncology services

- Port Hawkesbury Nursing Home
  - extensive waiting file (not a list)
  - bed shortage in hospital, have to take some first
- took a long time to build LTC in PH, 53 beds, need more, lobbying 3 years
  - sometimes have to take people from other areas, elder abuse etc.
  - moratorium on building more beds,
- increased cost in keeping the people in hospital beds

- as a mother, daughter, granddaughter, etc. I knew I wouldn't have the services I had in the city, but the level of service provided in rural areas is abysmal, we all pay the same taxes, we should all have the same level of service
- in an urban centre people get service more quickly
- councils need to have rural representation

- from Port Hastings
- 12 years with Chamber of Commerce
- my friend Rilla needed transportation
- the reality is folks, different people are hanging out with different needs
- the reality is for our community
- I think that in the greater St area we have the highest group of young retirees in the province
- I am anxious to form a 50 plus club to mobilize and motivate the young retirees to address issues related to elders, children, abused, health
- we have chosen to live here, we need to start taking care of ourselves, it is only by starting to take care of ourselves
- make everyone introduce themselves

- community options for housing and LTC
- brain injury - continuum of care
- persons with physical disabilities, accessible housing
- young clients, need placement options
- adaptive aids programme needed for the province

- had cardiac arrest in 1995 and wouldn't be here if it weren't for the nurses

- CHB plans
- it is not just a list of services we must give but we also need to address the standards related to accessibility etc
- need to address the rural nature of the community and transportation issues

- higher proportion of elderly than in the rest of the province

- ambulance service - many communities have lost ambulances - good reports in this service, but need to supply additional information on wait times etc.

- boards need to be responsive to community, stop changing it every few years and let it develop

- acute care, home care and LTC are poorly coordinated and integrated.

- 30 to 40% of ac beds filled with long-term care people

Sydney

Five Items:

1. Brain injury must be recognized as a distinct and separate disability in Nova Scotia.

2. The continuum of care for brain injury survivors needs to be clearly defined.

3. Community support centres for the brain injured are needed in each county: a centre that is community based, consumer driven and operated by its members, the Brain Injured of Nova Scotia.

4. There should be a registry of brain injury survivors established in Nova Scotia.

5. Conclusion:

   - The Nova Scotia Provincial Health Council has the power to change public policy regarding health care, therefore it can recommend that applicable changes be made to classify brain injury as a separate disability.

   - Therefore treating citizens of Nova Scotia who suffer from brain injury with dignity, respect and equality.

   - Allocation of tax dollars must be provided for rehabilitation of brain injured Nova Scotians. This is the responsibility of all Nova Scotians.

Group represents people with all forms of allergies: food, airborne materials, pollen, chemicals. They have been attempting to get treatment provided for people who are particularly sensitive to exposure to chemicals, carpeting and underlay, foam cushions, modern furniture, building materials, sealed buildings. She has been ill as a result of working in a sealed building, where photo chemicals were used, when only 10% fresh air came into the building.

Some members of her group have suffered air quality problems at the Cape Breton Regional Hospital.

Some of the symptoms are memory impairment, perception dysfunction, and pain. Conventional testing does not always indicate environmental illness. As a result, persons who have environmental illness usually have to pay for their own treatment.

The only clinic treating environmental illness is at Fall River. Satellite clinics are needed throughout the province. The group is currently lobbying the government with this petition, and produces a newsletter, which is distributed to grocery and health food stores, and the local hospital.

Comments:

- A woman has an illness due to the air quality at the Cape Breton Regional Hospital, where she had been employed. Even surgery did not alleviate the illness.

- A gentleman stated he suffers from environmental illness, from inhaling chemicals used in a hotel swimming pool, during his employment over a 7-year period. He has developed leukemia and diabetes, taking medication and injections daily. He has seen many doctors, both in Halifax and in the United States. He now travels to the Mayo Clinic in Boston for treatment. The environmental clinic in Fall River has 150 people on the waiting list, equivalent to 4 years. First, there must be a diagnosis of environmental illness. If someone can get the treatment, he will feel better. Mr. Moore said he believes that chemical exposure is a form of brain injury, and has experienced brain fog, or total loss of perception of his surroundings. He has endured emotional and financial stress, and has paid $163,000 so far, exhausting his savings.

Introduced group and explained that they participate with the Aids Coalition in needle exchange. Her group initially concentrated on prevention but did not have much success. They now provide needle exchange and disposal, alcohol wipes, condoms. Hepatitis C is more contagious than aids, and there are now 2,000 in Nova Scotia, 600 in Cape Breton.

Testing for Hepatitis C is not a standard test, and must be requested. The group would like to see anonymous testing in Cape Breton, available only in Halifax; they also would like to have a haemotologist in this area. Compensation is available for some victims of tainted blood, but not for those whom they infect. Symptoms of Hepatitis C include fatigue, nausea, brain fog, diarrhea. The group encourages people to be tested and are posting notices in doctors' offices.

Comments:

- A young man in attendance, victim of a car accident as a child, asked about assistance in finding employment. He was referred by members of the audience to the CAA (Canadian Automobile Association) and to also check with some insurance companies who offer rehabilitative employment to accident victims.

- Would like to see more preventive measures, early intervention, and follow-up. There is no cardiac rehab, no pulmonary rehab, we need satellite clinics; physical rehab has long waiting lists. Difficult to stay healthy waiting so long. People go to emergency and wait long periods of time; doctors should keep their offices open longer, and we need more doctors. A lot of people survive here without any great care.

- Trauma for people traveling to Halifax.

- Attendee stated she has a brain injured brother and there is no funding to take him to Halifax for treatment.

- You can't have a healthy community with toxic chemicals in the environment, unsafe water, a sick hospital.

- perhaps preventive medicine needs could be partnered with insurance carriers (Etna Insurance Company partners).

- Mental health services are lacking, with long waiting lists and poor follow-up.

- Children in psychiatric care are placed with older patients; same in addiction services.

- Small Options Homes - consideration is being given to moving these residents back to a mini-institution.

- Braemore Home - feel the residents are over-medicated.

- We need more:
Senior citizen homes
Home care
Palliative care

- Education is one of the most important aspects of health care and health issues should be taught early in school.

- Child poverty means family poverty, resulting in poor health.

- Media should be in attendance at this meeting.

1. Summary

When the community health boards are established, there will be 3 boards: Northside, Sydney (15 members), Glace Bay/New Waterford. Volunteers will be sought by application (deadline March 1st), appointed and will comprise two-thirds of the boards' membership.

There are several sub-committees of the Provincial Health Council, including Patient Bill of Rights, Mental Health Issues.

All information from these public sessions must be submitted by mid-March, with a completed report due in mid-May. This final report will be made available to the public for comment. Our web site can be accessed for review and recommendations.

Upper Nine Mile River

East Hants Community Health Board

- Slide shows East Hants
    - Regional Health Board changed - health plan was formulated and submitted
    - Community Health Boards will continue and will become part of new DHA
    - Volunteers from all parts of municipality
    - Diligent work by all parties
        - Series of community meetings and meetings with providers to create community health plan
    - Extensive community activity to involve
    - We heard:
        - Health delivery in East Hants is very confused. Do people go to Windsor/Truro/Halifax or where?
        - No focal point for heath delivery in the municipality
    - Rapidly growing population particularly in Enfield to Shubenacadie
    - Large rural area - services do not exist
    - Traveling long distances a major problem

Slide 2 Recommendations

- Partner with others to develop an East Hants Resource Centre in Elmsdale
- Is a health centre to be part of the resource centre? - no approval received from government to date
- Facility could provide basic diagnostic services and could be expended later

Slide 3

- Need to have clinics in other parts of the municipality
        - There is one in Noel - should be one in Rawdon
        - Nurse practitioner needed
        - Basic diagnostics - e.g., x-ray, blood work, etc.
    - Need to work with the community to meet local health needs
    - Presently working with doctor who is prepared to move to the Rawdon area

Conclusion

- East Hants has over 22,000 residents and the poorest support for health services in the province
- The development of a health centre would go a long way toward correcting this problem in the municipality

- Planing for the resource centre is in the planning stages (probable placement in corridor-Elmsdale)
- Working on a presentation for municipal council for Feb./Mar

- Referring to the workbook
- Requires a lot of time and thought
- Rather murky process
- Problem with rural versus urban
    - Urban community is different than rural communities
- Ambulance was removed from Upper Rawdon
- Feel ignored by PHC as well
- Transportation is a big problem
- PHC should consult with Community Health Boards regularly
- Health system has been studied to death
- You need to talk to the citizens about their own needs
- Has changed everything in the book to District of Rawdon

- Biggest problem is with regionalization - already have 2 regions - the corridor with approximately 10,000 within urban - Enfield, Elmsdale
- Rural with Nine Mile River
- No contact made to their clinic to ask their input - they are the gate keepers and were left out of the process
- Majority of patients are oriented toward Halifax
- Approximately 15% of patients go to Windsor or Truro
- They should be central region oriented rather than northern
- 1942 existence - 58 years and still didn't consult with the medical centre
- Elmsdale losing a family doctor and will be overworked with 14,000 people
- The doctors there won't provide help - nurse practitioners need a doctor to supervise them

- Did consult with the medical centre

- Doctors in Elmsdale are extremely busy. Difficult for them to attend meetings or visit patients outside of their offices, so consultants and patients have to go to clinic to talk to doctor

- Did ask the doctors in Elmsdale to attend a focus group
- They invited through Dr. B. Montgomerie

- Hears what Dr. Montgomerie is saying and respects him
- Nurse practitioners a good way to go to lighten the load on the more professional doctor
- The legislation requiring doctor supervision of nurse practitioners may be self-serving
- In the north - nurse practitioners do it all
- Nurses can do childbirth things
- If legislation prevents nurse from doing what s/he is perfectly capable of doing it should be changed
- Nurse practitioners could be perfectly adequate gatekeepers to health care system

- Elmsdale Medical Centre - couldn't give appointment for 8 days after he had been 12 day sick. But if it was an emergency she could wiggle him in
- Access to doctor's office is major problem

- Residents scatter for their care
- Possibility of having doctor in Rawdon is definitely worth exploring
- The doctor they have approached is not concerned about the amount of work available
- Waiting for doctor appointment is a problem
- Some aging population in Rawdon area
- Transport is a problem
- A centre in Elmsdale is a good idea
- A centre in Rawdon is necessary
- Establish an outlying area to complement the services being offered in the corridor
- Primary health care needs to be enhanced
- Ambulance service was moved to Kennetcook
- EHS/EMS has ruined the service they used to have. The area is often left without coverage as the ambulance moves out to cover other areas
- The only emergency coverage here now it first responder service through fire department
- Have 6 first responders in Rawdon Fire Department
- Increased stress on them - dearth of volunteers for the fire department as a result of increased stress

- Fire fighter first responder
- A lot of training
- When ambulance left Rawdon it was to be 24 hours in Kennetcook - however it is there less than 50% of the time
- Need to keep the ambulance in Kennetcook
- Used to be 3 in area - now only 2
- Response times for EHS are very slow

- Rapid learning curve
- No matter where you live in Hants East you should be able to expect the same services for your tax money
- We have a piecemeal approach to community support
- Small communities are discrete entities
- PHC should take away from meeting that the people are the same as people everywhere
- Service may not be equal but should be equitable
- Concern re: where ambulance is stationed and how it gets to where it is needed
- Vicious circle - no doctor - young people move away - lose school, can't get a doctor
- Supports nurse practitioners
- Feels need to give incentives to rural Nova Scotian kids to go to medical school and return to rural Nova Scotia
- PHC should think about East Hants being equal to other areas of province

- In Elmsdale
- Very fortunate to have local doctors and series 100 highway

- Why aren't we hearing from local industry

- They generate tax money and jobs
- They employ approximately 100 people
- They have over $10 million investment in the park alone
- Growth in East Hants is going through the roof
    - Most in the corridor
    - Probably 10-15,000 in next 10 years
- Over $200 million through Hants County development in last 10 years
- With people moving here we need centralized services
- The resource centre in Elmsdale was originally a business idea - not health services. However we are now going to gather them all into this centre
- We need to have quality health services
- We hope to have better services
- We should be demanding the best we can possibly get
- We need to have services out here not just expand the Cobequid Centre

- Talking mostly about primary care
- We also need to think about tertiary care - we are a short distance from Halifax - best east of Montreal
- Primary care needs to be in the community
- If you do provide diagnostic service where are the x-rays to be read, where is the blood test to be done
- Don't let the government tell you have to go to Truro when Halifax is so close
- Truro is trying to increase the amount of work in Truro but we need to make sure we preserve our right to go to Halifax

- Lost doctor in Noel
- Lost doctor in Kennetcook
- Why can't the communities support the doctor - free rent, free oil, etc.

- Referred to Bridgetown situation recruiting his brother - Bridgetown is his hometown
- Also have difficulty with ambulances
- Choices about where to go
- Don't have enough physicians
- When call 911 - the patient is told where they will go and the ambulance driver won't listen to the patient about where he wants to go

- Ambulance services
- Brother has diabetic seizures
- Only ambulance he could get was from Bedford and took the patient to Truro

- Ambulance won't take patient where they want to go
- If they take patients to the wrong hospital they don't have the records

- Mother of 4 boys

- Husband had MI
- Mother has Huntington's disease
- Happy with services they have used so far

1. Hope I always have the right to say where I want to go
2. Should be a clinic in Rawdon - health needs to be a core subject in schools - especially discussing our responsibilities with health
3. Multi-purpose centre in East Hants - if population in Elmsdale put it there - nutrition, mental health, exercise, drugs, alcohol, gambling, help for health care givers - specialists coming to centre
4. Should be nurse practitioners there
5. In QEII last week - brother-in-law injured in forest - discharged with IV in arm - place like a 3-ring circus - doctor, ambulance, police, etc., crazy place
6. QEII overworked

- As first responder can you call air lift
- Yes they can call STARS (air ambulance)

- From Rawdon - waited many times for ambulances
- Need satellite clinic in Rawdon
- Need service for young people with mental health issues
- Distance in a big thing - need local service in Rawdon

- Establish a relationship with your family doctor
- I wouldn't take my cats to Colchester Hospital
- The cardiac unit is terrible
- if she could choose 3 services, they would be:

1. 24 hour emergency care
2. Family doctor in 25 miles
3. Diagnostic centre within 25 mile radius

- In Nova Scotia we have 1 centre - Halifax - that is not far. There should be 3 centres across Nova Scotia, not just 1
- Good cardiac specialist service here now

- Lived in Enfield 25 years
- Level of care generally good
- Confusion as to where to go
- The providers also need to consider the knowledge of family members (acknowledge that there is abuse by some people)
- Disability is a major barrier
- Wait times are too long for consulting with specialist services
- Having to transport a family member from here may cost the breadwinner a day's work
- As I age I see a need for home care support - the service just isn't there
- Don't remove people from their own communities for placement in long-term care facility - creates tremendous stress

- Upper Rawdon

- Aging population and school of 200 kids
- We need something in Rawdon
- The community is prepared to work toward a clinic in Upper Rawdon - already have the land, the doctor is provisionally arranged

- Wait at Cobequid - waited hours for blood work and then was sent home and told to come back tomorrow
- Ambulance won't take you where you want to go (I insisted)
- Called an ambulance - fire hall in Upper Rawdon had to bring oxygen. Ambulance said there was no Route 14. They finally arrived at least 1 hour late
- We need a centre here - for elderly and handicapped

- Subtle move by the Northern Regional Health Board to direct us to Truro
- We don't want to go this way
- Lack of ambulance service
    - Lack of knowledge by dispatchers of geography
- Our council and majority of citizens are aware informally of resource centre and will support
- Concerned about health care and lack of it here
- When you are ill you shouldn't have to decide where you need to go or want to go

- Support what people are saying here at meeting
- A lot of underlying passion in East Hants
- PHC - need to hear the stories but also need to understand the needs for preventative, education, life style choices, and supported in very broad way
- Make more noise about life style choices but return the information to the communities - support and reinforce the good news stories
- 3 messages
    - The communities know themselves best - don't disregard what they say, boundaries that are set for administration are artificial - need to be flexible
    - The silos have to go down
    - Health has to be approached over the long term - don't let the government change it every time they change

- All fire departments in East Hants provide first responders
- Some even carry defibillalator
- Only 2 ambulances covering this area
- Local fire department will respond even if the ambulance is away

- Centre Rawdon
- Works for Department of Agriculture in Truro
- Need to have safe farm practices program
- Government considers Centre Rawdon a remote area

- Works part-time for local MLA
- Remote roads are difficult
- Department of Transportation says it has been cut so roads suffer

- PHC and people here should press government to create a strategy to develop worst roads

- Will be municipal government owned
- Tenants pay rent
- No provincial funding
- Community Health Board working toward health centre in building
- Public health and health centre will be there
- Family and Childrens' Services will be there

- Need physiotherapy
- Pharmacy
- Need support staff and resources

- Need the health centre in East Hants
- Don't need the resource centre

- Need Health Service Centre in East Hants
- Cobequid Centre is now too small for its population base it serves
- Put the services here in East Hants now because that's where population is building
- Model being talked about is the one in Windsor
- Put a wing there

- It would be wonderful to have everything but we need to start out small and add on later - if we asked for everything now they will laugh at us

- They're copying idea from Windsor
- There's a problem in East Hants - we have service spread from here to there
- The building is supposed to bring all the services under one roof
- East Hants is a growing community - it needs diagnostic services, etc. now - not 20 years down the road (will be growing for the next 10-15 years)

- Need MLA and ombudsmen to get together for roads

Weymouth

- 3 points -
    - consult with care givers
    - 2 hours of respite care per week is crazy
    - promote exercise, organic food
- encourage people to plant native trees - but don't put local nurseries out of business
- Look at alternative delivery systems

- Written submission
- Western Regional Health Board from '94 to '98 as a volunteer

- Took $8 million out of Western Regional Health Board
- 15% of Western Regional Health Board is equal to $19.95 million cut if the government goes with the 15% cut
- 98/99 - $2 million deficit
- QEII - $20 million deficit
- Don't punish western region disproportionately because they lived within their budget
- Many plants have leaking roofs - $23 million repairs needed
- Addiction services - look at Sheraton Casino writing a cheque direct to Addiction Services
- 2748 people this year received services from Addiction Services
- Keep service in Clare in French
- Mental health - doing a great job
- Regional Consumer Advisory Board needs to be kept
- Keep bilingual counselors
- Digby had 15,000 emergencies a year
    - 5,000 clinic visits a year
- Cuts in Digby will affect Yarmouth and Clare
- Personal family used services at Yarmouth Regional Hospital and Valley Regional Hospital had great service

- We need to encourage the government to put more money into wellness rather than sickness and into follow up - Digby hospital must remain and be encouraged to do more things than it does now. (The government needs to look at where money is being spent, e.g., Queens General Hospital and Annapolis General Hospital are too close to other hospitals. We need to look at where these are.)

If the community wants to financially support that's great, e.g., Bear River Clinic - empowers community and young people. We need to support this development. Digby County - has anomaly - Digby Neck and Islands. Keep Digby Hospital.

- Reading Vanguard - good editorial re: specialization in rural area versus Halifax
- QEII report card last week
- If Halifax people had to come to Yarmouth for specialist services how would they complain
- Don't know what the answer is
- oncology visits, discontinued - now have to travel to Halifax
- Government must come up with solution to the rural areas

- Add to that
    - Have to wait 4-5 days for x-ray. It is not a core service
    - Don't cut services to make the waiting lists longer

- High deficits
- Need to look at provincial health goals and now we measure achievement
- We need to look at a different way to pay physicians. The present way of remuneration doesn't led to health promotion, prevention

- Wants doctors on salary

- See determinants of health in the paper every month - showing how we are doing and going
- Doctors on salary may not work because they get paid if they don't see patients
- Need to build in accountability

- DOKS Ontario system
- Pilot project being funded by Health Canada

- Representing people in her municipality
- There are not enough beds for emergency care in regional facility
- Concerned about cuts that may be made to Digby General Hospital
- Will there be diagnostic services - where will they go and how will they pay for them
- Have to go to Yarmouth Regional Hospital for eye surgery
- Transport is problem
- Cost associated with accessibility
- Will all money only go into regional hospitals or the QEII
- Or the IWK
- Population is aging
- Cancers treatment not available locally
- Pathologists say not enough time to double check tests, this scares people
- Worry about registered nurses diagnosing people
- Don't privatize health care
- Our area - low economic area. People not able to afford food, heat, medications
- People don't want to lose what they have and want services enhanced in the community

- concerned re: duplication of service
- Don't repeat all the tests every visit
- Halifax is central for Atlantic Provinces. Need to look at the finances here and ensure adequate contributions by other provinces
- Need more consultation with the nurses, etc., providers
- Need more heavy level long-term care beds but there is moratorium - look at regions not the provincial average
- What is the Department of Education doing related to health status
- Revenue Canada and deductibility for income tax for travel over 40 km - discussion
- Need to reroute patients to appropriate care giver (40% are counseling visits)

- Long-term care is problem - Yarmouth Regional Hospital 20 of 144 beds had long-term care patients blocking beds
- Need more long-term care beds or support home care

- Occupational therapist in hospital (is also manager in Western Regional Health Board)
- Digby County has a rising aging population
- Higher than provincial and national average
- Growing problem
- Beds are labeled acute care - but may be filled with people not needing strict acute care
- May need restorative care, progressive care

- QEII does have these services but we can't get our patients into those beds, there is inequity in access

- Facilitates support group of mental health consumers
- Deal mostly with depressions
- At January meeting - 4 members filled out books, some called 1-800 number
- Health care is more than broken bones and flu shots
- Mental health has been studied to death with Royal Commission, focus groups, etc.
- Tip hat to Western Regional Health Board - empowering consumer to participate in own care, Consumer Action Network - and Advisory Committee
- Tip hat to Doug Crossman
- Disappointed with dissolution of Western Regional Health Board
- Provincial government - $500 million deficit looking at cuts again
- Take report to government - hopes they don't put it on shelf and forget about it
- Consult with mental health personnel - Doug Crossman especially and CMHA - to see direction mental health services are taking
- Don't forget the poor sister - mental health

- Are there other PHC's in other provinces?
- Disturbed to hear about millennium projects, e.g., $98K to translate "dumb blond" joke book - we could put our money to better use
- Works in community - hospitals are very good but they don't go far enough - applaud the PHC - goals
- We need prevention, but also need primary, secondary and tertiary services in community
- Works with family violence - have tried for years to get funding from health, education, other bodies to deal with this issue

- Primarily nurse
- Pre-hospital care with EHS
- Need to focus on prevention
- Lalonde Report 1974 talked about participation
- Need more focus on prevention
- Will always need to have acute care but we need to move toward primary care
- Need to support expanded role of all health care providers
- All professions are experiencing shortages
- How can we best use the HR we have today
- RN's role to take over doctor
- Paramedics can assume other duties
- There are regions in community without services
- Friend lives on island with no nurse no doctor but owns an ambulance, they are lobbying government to expand role of paramedic
- Hubert d'Entremont - provides service but users must pay for his service
- Cutbacks always focus on promotion and prevention
- Education - what are we going to teach from primary on so the children will grow up knowing how to remain well
- Don't focus on "when I have my heart attach" - focus on preventing the MI

- Services - health promotion and illness prevention services are not available for seniors - e.g., need teaching re: medication interaction, diet, activity
- Focus on prevention and promotion will help in the long run

- Considered senior citizen
- Live in Digby
- In and out of hospitals
- Well treated at hospitals
- Health service we get stinks
- Refused admittance in Halifax 2 years ago when had MI and was sent to St. John by helicopter
- Recently went to eye doctor, going to be waiting over 1 year for laser surgery - can't buy insurance, doesn't have money to buy service
- I urge you to think about this. Is the government going to decide who will live or die?

- Friend with liver disease
- Made 3 trips to Halifax and 2 trips to Yarmouth Regional Hospital and visits were canceled when patient arrived
- No co-ordination, no consideration re: time re: travel from Digby to Halifax
- Palliative care - why doesn't Nova Scotia recognize this program

- The ambulance system - patient in hospital transferred - in current program you will be billed for inter-hospital fee $50 - just because the service isn't available locally and patient has to pay
- Illness is an extra financial burden

- Ask about young man in Toronto who died - hospital services closed to ambulances but would have been treated if he had arrived with his family and no on ambulance
- Do we have a false security with an ambulance on every corner?

- Back in 60's and 70's when we became a socialist country we were encouraged to borrow money internationally - our current financial situation is being pushed by international banks
- Need to reduce the deficit and to balance the budgets
- The exercise we need to do here is to convince our politicians to be creative in the way they deliver services
- R Kline was trying to provide user pay services (Alberta)
- We are facing this now - we have to cut - how do we make the best use of our limited resources

- New member of Community Health Board
- Aging population
- We need more long-term care beds
- If family members want to stay home they need financial support to keep them there
- Stress - people need someone to listen to them - suggest possibly a 1-800 number for the province to provide a listening ear (need help line)
- Need a lot of doctors. Moving away, RN's doing the same thing
- Government needs to provide incentive to retain human resources
- Closing smaller hospitals - don't close, make into community health centres, visiting specialists, etc., keep the facilities

- RN's are very capable of giving needles, doctor (own) gives vitamin K, B, etc. - nurses could provide the services and remove some of the strain from doctors.
- We need to fix our hospitals - structures, equipment, etc.

- Government should put extra tax specifically for health care

- American style 2-tier health system
- Lived in States for some time
- Our system is so much better
- What do we have that works
- Don't disenfranchise the poor
- The US system is based on profit not health
- Not in favour of US companies coming here
- Look at what made us a good country
- We need to continue those practices
- We need to come together and work together - what we have is what we have. Don't look for the pie in the sky
- Health care system has many faults but don't trade it for other types
- We need to use what we have more effectively
- We also need to lead the way, do what we can for ourselves first and then role of government is to supplement that
- The whole burden shouldn't be put in 1 envelope
- We need to look after our own health - more and more services being provided won't fix the problem

- I agree with previous speaker
- Many communities need more long-term care beds
- Meteghan has extra beds
- No waiting list at Villa Acadienne
- Nurses can only do so much, they are very capable
- Need to bring diploma program back in for nursing
- Entry to BN program - 4 years - poor job opportunities when finished
- Doctors are very busy - we need to educate the population as to what the doctors are needed for

- Believes in prevention
- Need to strengthen the family
- We are taxed too heavily in Nova Scotia - need tax break for stay at home moms

- Was on task force on nursing
- Dust it off and use it
- Community Health Boards excited her
- Communities would be asked what will help them
- Are they going to listen to us anymore than they did before
- Budget cuts in all departments will have an impact on health
- Need to have across the board cuts
- Very cynical (she was a past Western Regional Health Board member)

- Has all been said before, now do it

- Say to government - this is the last time we are going to tell you

- Limited money
- Need to consider ethics committee to look at the system to see what programs should be scrapped and what should be kept - need to look at best bang for buck and best return on our spending

- Home support
- Role is much different now than it was before
- Health care should focus on respite care, palliative care, not on housework

- Renew within five years

Windsor

Don't have enough resources - all places. Within region, everything is cut too close. Bring nursing school in for a two-year program to resolve nursing shortage in the province. It's crazy to look to bringing in nurses from other countries to do what people here can do. Modify program to solve shortages.

LPN's - a lot in the province. Should be some sort of bridging program to bring them into RN program. Would relieve some of RN shortages.

- Don't think there is legislation for government saying can't have program but may need government to say this may be a solution. If polled, may find people what diploma program back. Alberta had bridging program.

Understand will give year in program if have experience nursing to take degree program.

Have great shortage of physicians in area.

I make up the schedule for emergency. Real struggle from month to month. With new department hope there will be changes. Nobody to recruit or to make things attractive for people to recruit. Nova Scotia is not attractive. No long-term planning. Need 15 year plan for health care support from party politics. Need more resources for hospital. Can give you a long list of what we need. None of this is new. Are you going to make a difference?

In country with health care usually happens in west and drifts into eat. You're asking government to do something that hasn't been done. When can we expect to see the result of what you're doing?

Have to have report done in mid-March. They are working on transitional plan now. When we submit our information, they will meld the two together. When the Department of Health spends money, it is supposed to be waiting for this core clinical piece. People have said we're being set up. If I believe this, I would be home right now. The department has made substantive changes so face like an information officer. Now we can get some decent information out in the field.

When get information, it's flawed from the beginning. We do need information technology to talk to one another from hospital to hospital. A few of the managers here would love to say how long it takes to do pay sheets. The time it would save would be tremendous. Doctor can't get any information on patient in another hospital in the province. It's all a manual process. Is big issue. Collecting data, there's no emergency department with data base on what they've done, who they've seen. That's another instance of care issue that will come back to bite us. It's been proclaimed by the Canadian Emergency Physicians Association.

We've had concerns with information technology.

At the community level if go to Community Services but if go to health, there's a gap. When patient leave, no integration with policy and planning. Amount of assessment and duplication and gaps it leaves is very frustrating.

- See health in broad sense. To use resources wisely and to eliminate gaps is my biggest problem. There has to be legislated commitment. I think we would have to enforce it in some way.

Don't' have resources to assess it. You can't get it for everyday problems. Can only do so much to teach people about their health. There are a lot of points a person can't go beyond without supports.

Average person doesn't even have negotiation skills to get through them.

There's no assisting people, no attempt to bridge to some resources available. They get tired of going again and being refused and being demeaned. Not user friendly. Lacks integration, lacks flexibility.

You have to have those properly funded to use them. If only have one social worker in hospital who works with in-patients but see someone who will become an in-patient, where do you draw the line. If don't have enough people to work with people, you ____ them it can't be done.

No one takes ownership of the problem.

Need for community - triage. They closed beds in province. Did they do study to find out if they closed too many beds?

10-15% of beds filled with acute care, there is nothing for them. We're keeping them 24-48 hours on a stretcher. This isn't new.

In last few years started seeing more recommendations for acute care patients. Can you send person to dietician. It's telling me I'm going to be seeing more clinical than preventive type work. The specialties aren't being made available.

- Whenever there's waiting time for service is there any way we could have structure for waiting time?

We decide what's a reasonable time based on how bad it is. It all depends on what it's relative to. You have to gauge what you can accept as a person but that doesn't say what person is waiting. If just use waiting times in diabetes centres in province, waiting time has improved but quality of care has gone down. No follow up. There's no improving anything, it just looks better. You have to be careful with waiting times.

Not resources from mental health and alcohol abuse. Nowhere you can send people.

Nowhere you can send people with mental illness to get advice. Not necessarily mental illness, I'm talking about counseling.

You can't provide everything for everybody. Nobody's made decision in province of what's important. Everyone's scrambling for resources to do their job.

Think should do the most to get politics out of the emergency department.

That's been said in other places.

Seems to be so many gray areas above us. Money being used for ____ all the right reasons. Asked by cancer group for history on drugs we've used. I thought I don't have to do that. I worked here 15 years, reported the figures for the department of health, and no one has a record of them. Have to write over them because hoping now someone will do something with figures. Got very frustrated. Wasted time compiling figures and now have to back track. We work so much like that. It's waste of money.

And if it's more than 7 years old it's destroyed.

Changes in regionalization bringing more accounting work. We have our own case load of patients we work with and we're cutting that to do more accounting procedures that someone else did somewhere. Even though saving with accounting departments, you're taking it away with people who have to work with patients. I can't imagine someone deciding that's a cost saving way.

Because of geographic area it's imperative keep emergency, etc.

And because of lack of integrated service we sent people to. Those places don't have any more services than we do. Can spend 3-4 hours to get an ICU bed in another hospital. Told to task force and Central Regional Health Board for 2 years I've been involved.

I came to see we don't lose hospital. Happy with what we've got.

We're not going any further because a doctor (from her area) resigned. Had a doctor and a quarter. Now she left altogether. Doctor is booked full all the time and doesn't want to take on more. We burned the doctor out. One doctor and don't want to burn out another. Don't' want to make another work 24 hours a day, 7 days a week. We would like to have another doctor in our area. Doctor in Noel is ready to burn out. Up in that area going to have trouble, too. Shore will be in bad shape with doctors and then Windsor will get it in the neck. Know it's going to be worse because of situation developing on the shore. It's hard to get a doctor. Think would be a good idea if we had nurse practitioner on shore working with in clinic, it would make a big difference. It's a problem all over getting adequate heip. Husband is a patient waiting to see a doctor for collapsed kidney. Have to wait another month, and its' been 6 months since his last appointment. Six months is too long to wait to see a doctor.

Is it easier to grow a nurse than a doctor?

It's cheaper but they can't do as much as a doctor can do. I think nurse practitioner is a good idea. Nurses don't have the in-depth training doctors do. Pilot projects all over country putting nurse practitioners and doctors together. The problem is merging them together, the infrastructure.

We don't offer any incentive, not one penny in scholarships (for nursing program).

Only have the degree program (for nursing).

One of the biggest problems with shortage is burn out.

One other problem is many doctors don't favour nurse practitioners.

You have to have balance between hard stuff and easy stuff. Can't take away easy stuff from physicians and give it to nurse practitioners. I give flu shots and for some patients it's the only time I see them.

At least nurse practitioner is entry into health system. Some people without a doctor don't see anybody.

Some people don't have a doctor. Some doctors are so overloaded that they won't take patients.

I don't think we're doing a good job at education and prevention.

I don' think its' not that they're not aware. People you see with this have denied it. Has to do with people and the way they are.

Wonder if government is going to spend money now for long-term so in 20 years we don't have the problems.

If we don't get a handle on acute care, that's the part that's sucking up dollars. Have to do a good job at education and prevention.

What makes you think you can do a good job with equipment that's 25 years old? You can't have a system that keeps up with technological changes and an aging population if you don't put money into it. For instance, the Central Region went from 15 administrative staff to 40, when from deficit of $8 million to $14 million. If you duplicate 9 times what's been done 4 times, it's a disaster.

Have to re-establish all things you set up when you move. When starting, changing systems. It has cost because of how it has been done. Can't have the equipment, too (do it here and send it there).

The problem you're faced with, prevention and education, is important but how are you going to go from here to there? You still have to look after the person for the next 25 years and there's an increasing number of (aging) people. You have to get money from somewhere else, you can't take it out of acute care.

If you don't put money into it you have more people coming into acute care. If you look after them, they don't develop the problems and complications of being old.

Acute care here is very different from acute care in the QEII. Resources are different. Treatment options are changing and are expensive.

Per diem rates for Hants Hospital are under $300/day, and at the QEII are $1,800/day.

I Believe that our life style as a society is not healthy. Diets aren't what they ought to be. Exposures to pollution, chemicals. If we had a better understanding, more guidelines for diets, we could prevent a lot of illness we go to hospitals for. I think we have to give a lot of emphasis to that because down the road will be a lot worse. More people are going to be sick.

I think the biggest thing that determines health is genes, and you can't do anything about that. You can only change people with good genes.

I believe everyone will do better if the environment is good.

It won't solve everything.

There are life style factors that affect life.

Take smoking. That's one influence, and there are many influences like diet and environment. We can be working on those. People work on programs and I'm sure we can do it at the provincial level.

I taught program for 33 years in home economics. That program was stripped of nutrition. In order for us to survive notes pop machines and food in cafeterias that's unsuitable to eat. When I spoke about it, I was told we need money. There were three teachers dealing with teaching nutrition. Now I teach it. I'm looking at care load of 200-300 students. Parents won't choose to let kids get into program, they will choose computers. One of the biggest concerns is introduction of sexually transmitted diseases. Need clinics in schools who can give supplementary help to students in regard to preventing.

Seen less time over last few years choosing. Have to choose cooking or sewing, or band or music.

In early fall, I was doing food nutrition program and had a young girl very excited because her mother was going to purchase flour and sugar and stuff so she could make product because her mother buys everything.

My husband can't have salt. I can't buy anything in the store without salt. Can't buy anything in store that isn't high in potassium. Good thing I know how to cook.

Faced quite often with people who don't know how to cook.

One of the things I find in my job is education and lack of skilled labour in the province is something has to be looked at. Working poor can't afford medications and are becoming ill because physicians can't give samples. And see total lack of communication between federal and provincial governments.

Some professionals feel it's unethical to give samples.

I find if you integrate, you don't have to work as hard and do it all yourself. I think it's from the top down. I think it's top people who keep it from happening (departments working together).

We do what people will allow us to do, but there are rules and regulations with some government departments. If it's good will, it's temperamental. Had integration meeting here with services here. We had situation in emergency department where said you can have this and this, and I had to make calls and it went back and back, and finally we'll pay for it. Frustrating for the patient. We had to hop through 6 hoops to do it.

We live in a society based on power. Departments from government down all based on someone at the top and have to have power to support themselves and work on bureaucracy built around them. It means another growth centre for them to go to. That is the biggest area we have to concern ourselves with. Goes right down to organizations in the hospital or clinic is based on that. We have to use resources much better than we do. Have to channel them in the right directions and make people feel secure and work with one another.

Have solution - no one can be bureaucrat until worked as a clinical worker. If they continue to provide clinical services, they would know how things had changed. It would fix a lot of road blocks.

Easy to cut when you don't have to face the people affected.

If have 15 year plan and don't mess it up.

Need to build in accountability.

I think it costs consumers and tax payers money (changing regional health boards).

Told boundaries remain fluid (told by minister about DHA's).

Would like to see more support for new mothers and expecting mothers. If you have question or have different pain and would like to call someone. You can ask professional on phone or drop in, even with toddlers and infants, can only book in for needles so I'm always in out-patients.

Article in MacLeans setting up call centre.

Think would address what lady is saying. We're a transient society (moved away from mother and grandmother). With a nurse profession took away ability to provide phone advice. We've taken away a vital support system. Have to ensure advice is consistent and in language people can understand.

Place in U.S. with call lines. Hospitals lost business because of it.

PHC looked at call centre. No proof doctors and emergency had reduced visits. Would sot $3-5 million.

Would suggest (call centre type thing) come from family doctor.

What happened to the well baby clinics? It seems a shame we've become so sophisticated we've lost out on one of things in communities.

There's a theme flowing through the meetings that the pendulum swung so far with technology maybe we should come back. A women who has had 4-5 kids can't help a young mother?

Involved with family resources. Listening to baby situations, starting with baby love program. Give moms a chance to ask questions. And food situation to address lack of cooking skills. Most programs from high risk, low resources families. Drop in to the centre to offer support. But have financial problems. We can offer service to address these situations. Have grants from CHB, CHPF, Community Services, HRDC. Day to day existence.

Give information over the phone - weaning, breast feeding. Large part of what I do. It ____ me to think mothers don't have a place in the area to get information.

May be a barrier there, I call and get a machine.

I don't think a lot of people know that.

Agree with using peers. It doesn't have to be a professional to lead a group.

Can't do health promotion with second health services.

Can't take it out of high schools. That's where they need it the most.

I think it's important aspect of doctor to treat baby and get to know them.

Shortage came since '93. Changed education system from nurses and doctors. 1980-82 doctors from my class graduated. '99 class of 27 graduating from family medicine, many have gone south and other places in Canada. Resulted in shortage. Nurse program going from 2 to 4 years resulted in nursing shortage.

When we planned process wanted to move you into smaller groups and talk about what will make you healthy and what do you need in your community to allow that to happen, and in the region and province. Because not done in that way, that's stuff that comes out nonetheless. Haven't heard anything too new, heard frustration. Premier will hear that. Message loud and clear. Resources problem, shortage, lack of resources to serve your clientele. We're hearing you.

Yarmouth

- Brief presentation re: OBS service
- Encourage participation by public - need to have information to make reasonable decisions.
- First page gr - OBS - there are problems associated with the site of these services.
- Nationwide crisis in the number of MD/specialists who are associated with delivery of OBS services
- Provider assess crisis (see submission, asked by SOGC to produce critique)
- Many FD have decided they don't want to do OBS - smaller number of MD doing rural/local OBS
- Delivery in midst of office or night disrupts total office routine - burnout
- OBS specialists not coming to rural areas, want urban lifestyle
- 1600 OBS in Canada - ~/100 in rural practice - average age 54 (average age of Canadian RN 47)
- Specialists want to go to city or USA
- Talked to Muir and Finance re: this issue
- N.S. has had problem recruiting and training OBS
- Shelburne problem - smaller centres, women want to deliver closer to home. Shelburne has hospital 1980 built - local women lower weight babies have to go to Yarmouth or Liverpool
- These people need information re: human resources, facility structures, anaesthetists, etc.
- Submits that is our task as PHC

- Seniors throughout province represented
- 16 councils/clubs/20-800 members each
- 27 years as N.S. group
- N.S. Soc. Act
- Not all seniors and pensioners are members but are representing everyone
- All clubs discuss concerns of pensioners

- Three day seminar

Five categories
- Taxes
- Housing
- Nursing Homes
- Health
- Style

Taxes:

- Poverty 13/42 res.
- Seniors and women poorest in Canada
    - Getting poorer
- Need income supplement to bring up to LICO
- HST a burden - need rebate
- Federal clawback should be removed
- Drug prices need to be reduced
    - Lower price
    - Higher spending on research
- Feel there is enough money in the system to make it work - need co-operation
- National pharmacare supported - equitable
- National patient identification system and integrated information system

Housing:

- Costs rising
- People need to stay in their own home
    - Legislate low income rates for power, etc.
    - Full indexing of senior income
    - Eliminate taxes on seniors clubs property

Nursing Home

- Legislate
- Public funding
- Ongoing training for all staff
- Request residents of all nursing homes be covered under health budget
- Living units next to HSC for provision of service
- Boarding home subsidy for people able to stay there
- Senior citizens sharing rooms causes lack of sleep, etc.
- Live in care takers, to keep people home
- Legislate low incom[illegible]up under NSPC
- Dedicate portion [illegible]oney to keep seniors remain independent

Health:

- Diets - hard to read contents
    - Write ingredients larger
- Assist purchase - glasses, hearing aids and dentures
- N.S. government should legislate five principles of CHA
- N.S. Minister of Health set levels of acute care, long-term care, beds, etc. to ensure
- free of charge flu shots
- oppose further erosion of pharmacare
- Rural does need
- School gyms be made available for seniors
- Fishing licenses should be free to those over 65
- Gun laws need to be fixed
- Driving program cost seniors
- Parents are shackled by laws. Parents should be allowed to discipline

5:

- Opposed to drilling oil on George's Bank because of fishery needs of Western N.S.
- Support Devco - provide mine
- Issue savings bonds to redeem foreign bonds of debt
- Set up community based programs teaching parenting classes to young parents
- Set up recall procedures for MLA's
- Oppose federal government
- Minister of Environment - protect fresh water supplies
- Ask provincial government to respond in writing

- Yarmouth over 15 years
- Need to break down silos
- Community Services/Justice/Housing
- Framework for Action Against Family Violence
    - Based in Barrington
    - Barrington has highest level in N.S. and one of highest in Canada

- Funding under review - Justice Department
    - This program is very effective and fills a much needed void
    - Darlene Ross, Co-ordinator

- Funding April to June
  June to September
  October to December
  January to March December 24
- Re-iterate from Shelburne
- $35,000 - serves two counties
- Family violence stats have tripled in last year
- Education - higher reporting and awareness
- Murder/suicide Cape Sable

- Suicides of family violence victims
- Barrington high risk area
- Tells young people about victims, teen date violence, etc., human rights
- Urge PHC to speak about family violence and the effect on the kids
- Document and support letter provided

- Local Schizophrenia Society - Mental Health
- Has son
- Long-lasting effects
- Employment a problem
- ADL skills, for training, etc., needed
- Yarmouth Waterfront House - club house model is the way to go in mental health services
- Provincial Schizophrenia Society provides the service but is unsure of funding

- Line dancing for seniors
- First class 15 1/7
- Now 200 6/7
- 200 members, 125 filled survey
- 65 with arthritis, 8 with asthma, 39 with high blood pressure, 11 with panic attacks, 25 with stress, 34 with weight problems, 9 with diabetes, 11 with heart problems, 40 with high cholesterol, 27 with sleep disorders
- Exercise and being with people - healthy lifestyle
- Less anxiety
- Joints mobile/exercise mind to remember steps
- Appeals for help - need volunteers
    - Needs funding to hire some help
    - Benefits
    - See survey

- Government funded
- Funding ending - need to have Nova Scotia Government take over preventative and promotion activities instead of 30 level service after people get sick
    - Four areas
        - Services and policies - tobacco and seat belts
        - Higher standards of living - housing, water, etc.
        - Better environment - walking trails
        - Modify lifestyle - diet, exercise, smoking, stress, etc.
        - Investment in prevention provides rewards later
        - Safe cycle ways
        - Safe kids exercise areas

Health promotion/illness prevention
- Cardiac/respiratory/ca
- Last card
- CVD - highest cause in Nova Scotia and Canada, $7.3 billion in direct cost and $12.4 billion indirect cost

- 1991 - $2.5 billion for smoking

What do we do about
  - Responsive, evidence based systems
  - Invest in promotion, prevention
  - Fund front end
  - Yarmouth
    - Getting kids out to rink
    - Getting walking trails up to snuff
  - Government needs to lead support to community
    - Resources, policy (healthy public)
  - N.S. - higher communicable disease - CVD, resp., diabetes, promotion and prevention help eliminate
  - Preventative efforts smoking, lower nacl - lower strokes since 1991

- Help decentralize management of cancer
- Bring to regional hospital and community hospitals the expertise to Rx cancer
- Transport to Halifax is a problem for many
- Yarmouth Regional Hospital had medical oncology 2x3 days a week until two years ago was lost
- We need to do something to bring this back

- Studying gerontology
- For 93 mo 85
- Worked in nursing home
- Hospital overworked, long-term care over booked
- Lack of long-term care beds - some good home care support
- Put more money into home care and enhance
- Aging population - more demand
- Need to have better home support
  - Both physical and emotional and psychology
- Smaller families - lack of support networks
- Need respite care in community
  - Put more money into respite and support
  - Enhance home care support piece
- Higher cancer rates

- Panic attacks - once every two months - wake up t nights
- Mild depressions
- Bipolar/schizophrenic
- Government should support similar establishments in other communities in Nova Scotia
- Need stricter gun control
- Mental health needs attention
- Stigma a problem in mental health
  - Thinking about starting group called Stigma Busters

- Health care affects us all
- Not just a case of throwing money
- Needs to put sufficient funding into the services mentioned tonight
- Fill out over workbooks
- That and public meetings will give clear message to governments of province

- Education is major thrust of Canadian Cancer Society
- Do research
- Education re: prevention and provincial action
- Takes one person to close barn door up front. Takes 20 to catch the horse later and maybe a professional to fix after caught

- We need visiting neurologist in Yarmouth
- Transport is a problem
- Need bone densitometer - is one in Lunenburg (only two in province)
- Again travel

- Speaking as consumers
- Now a two-tiered system
    - Metro versus rural
- Time provincial government/QEII recognize this and redress the imbalance
- Example - VG should recognize geography., i.e., book locals in a.m., book away in later day (surgery work-up)
- Money will probably run out before the hospital is finished and will be difficult to provide the basic services
- We do have the right for local support and local service. Appropriate rehabilitative care is not available here. Patients don't go to Halifax and don't get better. They end up placed
- Minimize gap in care provision
- Need to be understood that metro Halifax is not the centre of the universe
- Transport costs to Halifax are high
- We have finite resources and infinite demand
- Someone has got to stand up and be honest with Nova Scotians and tell us what we can afford as a province. What is reasonable to expect.

- Workbook is a problem
- Questions are difficult to answer
- Most important question - should have been what is a reasonable time period for accessibility to service
- Second - what is an acceptable distance to travel for service
- Not addressing traveling clinics, e.g., neurology, phys med, oncology, etc.
- Concerned about lack of support for specialists to come to the regions and communities
- No breakdown of diagnostic service
- No good set out for determinants

- Not a doctor
- Not a businessman

- Fought regionalization
- Why did we pay all this money out for these people - they (PHC) don't have a business plan
- Why don't they go to the computers and find out why we have to go to Halifax
- We want to see results
- We have got to help ourselves
- Doctors are not listening to their patients
- Why don't we have access
- Call internist and get stupid voice mail
- Need to fix what needs fixing now and it is in the computer

- Bought computer last week - had a plan first
- Financial task force - is time to change
- Home financing is a big deal
- Government must be a monstrous plan
- Thought workbook was good
- Blueprint to building book 95 - still doing the same things here tonight
- Cynic - will be doing something five years from now
- We need to have more of these meetings
- Let's make a noise
- ?Printing a phone book - so we can get
- Why are we paying hospital tax on alternate medical care - e.g., homeopathic, alternate medicine
- Why don't our taxes cover some of the alternates available
- Is the government doing anything about this issue?

- Recognize the volunteer aspect of PHC

- Is the list to be inclusive or exclusive

- DHA - regional resources be the same
- Need help with recruiting of human resources for Yarmouth

- Hospital at Yarmouth was to be a regional hospital
- We are now less than we were before
- Money and emphasis should be put here

- Get an undertaking to Jamie Muir re: what the government can and cannot do

- Grievances with hospital and whole system
- Is becoming nauseated with the process
- Why are we talking about core services again
- We need to know that our work won't disappear with the next election
- This regional hospital is a dangerous place for patients at times
- Doctors are leaving - heading for dangerous crisis
- The system was sold out a long time ago
- The people need to tell government that health shouldn't be a political football

- Worked on provincial government committees
- Often see reach of brink of success and then fall apart
- Don't' give up - keep plugging

Appendix 5
Community Health Plans Summary

INTRODUCTION

The following is a summary of the issues presented by the community health boards (CHBs) in Nova Scotia as presented in their Community Health Plans. Twenty-two of the CHBs presented plans to their respective regional health boards (RHB's) between 1997 and 1999. All of the plans were reviewed to determine which issues were priorities for the community health boards and if there were any common themes presented across the province. The issues summarized in the initial portion of this document are the issues which most (i.e. more than half and up to all) of the community health boards indicated as significant issues for their communities. Prioritizing these issues was not possible as the methodologies used by each of the boards to select issues for discussion varied. This dilemma will be discussed in the section to follow.

METHODOLOGIES

Each of the community health boards used a variety of methods to collect relevant information for their health plans. Some of the most common methodologies included but were not limited to: focus groups, public meetings, surveys, needs assessments, presentations by community groups, service inventory, CHB meeting discussions, and written submissions. Information for the community health profiles was gleaned from Statistics Canada publications, needs assessments etc. Once the information was gathered, some of the boards used it to prioritize their health issues. If a method of prioritization was used, the CHBs prioritized the issues that were listed or mentioned the most frequently in the information gathered. However, most community health plans did not indicate how or if the issues were presented according to priority. In order to select issues for this discussion, the most frequently mentioned issues and themes are presented first and then some issues that were indicated to be of unique importance to particular CHBs are presented.

LIMITS

All of the health boards made some mention of the difficulties and limitations faced in developing their community health plans. Some of the limits included but are not limited to:

- Lack of community awareness regarding the role and function of the CHB
- Many of the CHBs felt they had insufficient time to complete the plans. As a result the plan is in draft form and may evolve as more issues and information are uncovered.
- There were difficulties in data collection. Some CHBs had to rely on data from 1991 from Statistics Canada, as they were unable to access data from the most recent census. Others mentioned that different organizations collect data on utilization rates cost etc, differently, therefore making it difficult to compare organizations. Also the Statistics Canada information often did not coincide with the community health board boundaries and the boards were forced to rely on census division data or data for the province as a whole to make assumptions regarding their particular populations.

- Since this is the first time CHB plans were created in Nova Scotia, the boards cited a lack of a model or template as a difficulty in developing the plan.
- Some boards felt that they did not receive enough information from the community.
- Many of the boards mentioned low response rates to request for submissions, surveys, community meetings, etc and as a result they had to rely on data generated from a small sample size.
- The knowledge and resource level of board members varied throughout the province. Some CHBs were provided with training and instructional material as to how to complete the plan from their RHBs while others were given no instruction or information regarding the project. Therefore, the amount and type of information presented in the reports varies throughout the province. This presented difficulties in summarizing the issues to adequately reflect the CHBs intentions and recommendations.

In light of the above limitations, the following recommendations for the future were presented:

- Provide the CHBs with tools and advice as to how to complete a community health profile and needs assessment
- Develop standardized methods of data collection
- Provide adequate financial and human resources to assist the boards in researching and writing their reports.

COMMUNITY HEALTH BOARD ISSUES

Health Promotion, Education and Disease Prevention

All of the CHBs referred to some facet of health promotion, education and disease prevention in their plans. Most of the boards indicated a need for resources to provide education to the public regarding healthy lifestyle choices and the types of resources available within their communities to assist with healthy living; as well as information as to how to access these resources. Several communities would like to develop educational programs regarding such issues as smoking, nutrition, etc, or the creation of wellness clinics, but do not have sufficient resources to do so. Many CHBs commented on the lack of funding available for health promotion initiatives. (For example the West Hants Community Health Board Plan quoted statistics indicating that only 10% of health care dollars are earmarked for health promotion and prevention.) It was also mentioned that cardiovascular diseases and cancer are two of the most common causes of death in Nova Scotia. Both of these diseases have been linked to lifestyle choices. Therefore if programs were developed to assist residents in making healthier choices to prevent these diseases, significant savings would be recognized over the long term. Several of the CHBs referred to a study indicating that for every dollar spent on prevention the health system would recognize seven dollars in savings.

Another facet of health promotion and prevention discussed frequently in the plans was the availability of community recreational activities and resources. The communities indicated a desire to expand and enhance their current recreational facilities and to develop methods to ensure recreational programs were not too costly for lower income individuals.

Strategies for Action:

Some of the most commonly suggested strategies for action on this issue included:

- The creation of a position for a community health awareness co-ordinator.
- The creation of a community health services directory, listing all of the health resources
- Non-emergency information line for health questions
- The development of or enhancement of a currently existing multi-service centre
- Provide resources to increase and enhance the availability of primary health care services

Home Care Services

Several aspects of home care services were referred to in all of the community health plans. Most of the CHBs indicated that this issue was of a priority for their community. Some aspects of home care which were referred to included:

- Acute Care Services at Home: Several of the boards mentioned the availabilty of acute care services in the home as a significant issue. Problems cited included improper discharge planning, poor communication to clients as to what they are to expect from acute home care services, and inconsistent eligibility requirements.

- Non-Clinical Services: The quality and level of non-clinical services varies throughout the province. Most of the boards cited a need to provide services such as housekeeping, friendly visitor programs, assistance with ADL's etc. It was mentioned that if these services were adequately provided some other problems in the system would be avoided. Two examples cited included: unnecessary injury to those people who may to try to exceed their physical abilities doing household chores, and premature institutionalization of seniors due to the fact they are not provided with adequate supports to maintain their independence in the home.
- Poor Co-ordination of Services: Several boards indicated that their residents had indicated dissatisfaction with the manner in which home care services are organized and delivered. There are gaps in the systems and often times clients have to incur multiple assessments and a duplication of some services before or if their needs are adequately met.

Strategies for Action:

Strategies suggested to overcome these difficulties include:

- Conduct an external review of Home Care Nova Scotia's polices and procedures
- Encourage and educate acute care facilities to conduct better discharge planning
- Provide education to clients regarding the level of acute care services which are to be provided in the home
- Provide funding for non-clinical services
- Provide financial support to low income individuals to assist in offsetting the cost of home care services
- Enhance or develop palliative home care programs
- Provide respite care for family members and other caregivers

Mental Health Services

The types and severity of issues surrounding the provision and availability of mental health services varies throughout the province. The most significant differences are seen between the rural and urban community health boards. Some of the more urban communities mention long waiting lists for services and lack of supports for families and other caregivers of mental health clients. Urban areas also refer to the lack of preventive services, which could help offset the severity of mental health problems. For example, mental health counseling should be available for youths to access before they are in a crisis situation and services should be available after office hours. There is also a need to educate the public regarding the nature of mental illness so that clients will seek help in a timely manner and not avoid seeking treatment due to the stigma associated with mental illnesses. In the rural communities the problems regarding mental health services can be much more severe. CHB documents indicate that there are insufficient services for treatment and follow up of mental health patients. The distance between some rural communities and treatment centers presents barriers to access. The lack of specialized services for youth and children was also presented as a significant concern for both rural and urban communities.

Strategies for Action:

Mechanisms suggested to improve the delivery and availability of mental health services:
- Satellite clinics for rural areas
- Educate the public regarding the causes and affects of mental illness in an attempt to reduce the stigma associated with the disease
- Extend hours of availability of mental health services in communities
- Provide support programs for families and youths to help prevent serious mental illnesses induced by stress and lack of a support network
- Increase the availability of supportive housing options for the mentally ill who are being placed in the community
- Lobby the government to resolve economic issues, which indirectly contribute to mentally health problems such as low income and lack of employment opportunities

Seniors Services

The population of Nova Scotia is aging. As the population ages and life expectancy increases the health care system will be required to provide services to a significant portion of the population over the age of sixty-five. Several of the community health boards presented concerns regarding the availability of services for seniors. Although some seniors issues were referred to in the discussion of home care, some other issues were mentioned in the plans that warrant a portion of this discussion. CHBs mentioned concerns over the type of housing provided for seniors. If seniors are to be maintained in their homes, then housing options, such as senior complexes, need to be equipped with adequate structural characteristics. In addition to avoiding premature institutionalizing of seniors, the system must be set up as to avoid institutionalizing people in their own homes. There must be adequate opportunities for recreational and social activities as well as transportation to ensure seniors are able to attend these activities. As the traditional family continues to change and our society becomes more mobile, a number of seniors will be without family members to care for them. Therefore they will need to rely on the services provided within their communities to assist with daily living. Some community health boards in rural areas expressed concerns over insufficient numbers of Level II and Level III care beds in facilities

Strategies for Action:

Some mechanisms suggested to help assist an aging population include:
- Improvements to home supports and home care as mentioned previously
- Improve and expand the types of housing options currently available for seniors
- Resources for the development of seniors programs
- The provision of respite care

- Training for caregivers and home support workers
- Development of transportation programs
- Development of educational programs aimed at seniors in areas of health promotion and prevention such as nutritional counseling, correct ways to perform ADL's etc.

Emergency Health Services/ 911 Services

Several of the rural comminutes indicated difficulties with the level and quality of emergency services provided. However, it is important for readers to note that the emergency health system in this province has undergone significant changes in the last few years. Some of the problems cited with the system were presented in documents written by the CHBs between 1996 and 1999, therefore attempts to remedy some of the problems mentioned may already exist. However, due to the severity of the consequences of possible inefficiencies in the delivery of emergency services, a summary of the concerns presented the CHBs is provided.

Some of the rural communities expressed concerns regarding the level of training provided to "first responders" (volunteer fire fighters etc.) These communities also expressed concerns over delays in response times due to the location of ambulance bays, improper civic identification of houses and roads, conditions of highways and difficulties in communications between 911 dispatch and ambulance operators. Both urban and rural communities expressed concerns over improper use of the 911 service. Some strategies suggested to overcome these problems include:

- Review the location of ambulance bays in communities according to the location of emergency calls for service
- Initiate a pubic campaign regarding the proper use of 911
- Provide "first responders" with the proper education and training (i.e. CPR advanced first aid)
- Lobby municipal governments to ensure civic addresses are clearly identified

Services for Youth

Many of the community health boards indicated the importance of the availability of services to support the youth in their community. However, only one CHB presented a concise definition as to what portion of the population is included in the term "youth". Based on the discussions in most of the plans "youth" usually refers to those aged 12-19 or those under the age of majority. Support services for youth were seen as an important mechanism for assisting youth in crisis situations. Educational programs to prevent addictions and the use of alcohol and drugs were also mentioned. In one rural community, the community health plan indicated that the presence of after school programs and structured recreational activities could prevent youth from engaging in potentially dangerous activities. Since an investment in youth is an investment in our future, programs and initiatives geared to this portion of the population were deemed relevant to improving the future health of communities.

Strategies for Action:

Strategies for action included:

- Providing funding for recreational programs for youth
- Developing educational programs on STDs, drugs, alcohol and other issues
- Providing families and school officials with supports to deal with youths in difficulties
- Ensuring that services to youth are available after school hours so affected individuals can access services.

Accessibility of Health Services

Several issues fall under the broad spectrum of accessibility to health services and several factors outside the health system impact an individual's accessibility to health services. Accessibility is affected by such factors as income and social status, type and severity of mental/physical challenges, education, social support networks, geographic location and genetic endowment. One common theme presented by the community health plans was accessibility to physician services. Several of the rural communities indicated difficulties associated with a lack of physicians to serve the population. Other communities with an adequate number of physicians indicate the community would face a crisis situation if they were to lose one of their physicians. Restrictions on the availability of physician and other medical services also provided problems for access for those who may work or study during traditional office hours. Unavailability and gaps in public transit system posed difficulties in both urban and rural communities for those without transportation to access services. A lack of knowledge regarding the benefits and availability of some services prevented some individuals in some communities from accessing services. The cost of some services and medications also limit the accessibility of these services for lower income individuals.

Strategies for Action:

Action strategies:

- Extend hours of physician services
- Enhance physician recruitment in rural areas
- Educate the public regarding the proper use of emergency room facilities
- Provide services for disabled individuals
- Evaluate public transportation options in communities
- Create partnerships with community organizations to ensure adequate transportation is available
- Implement educational and health prevention strategies suggested above to ensure that residents have knowledge of the health services available to them
- Work with other government agencies to ensure proper financial assistance is available to those who require it.
- Work with advocacy groups for the disabled and other disadvantaged groups to help overcome some of the obstacles presented to these groups.

SOCIAL AND ECONOMIC CONCERNS

Economic Characteristics Impacting on Health Issues:

The quality, availability and type of health services are not the only factors that affect the health of residents of a community. Several of the CHBs referred to factors outside the health system which either directly or indirectly had an impact on their populations' health. Frequent topics of discussion were the importance of maintaining an adequate income and high levels of unemployment. Several communities in Nova Scotia have relied on primary industries such as mining, fishing and the forestry for economic support. However, in recent years these industries have declined severely impacting the health status of the communities involved. An inability to acquire an adequate income can lead to health problems resulting from poor nutrition and inability to afford rehabilitation services, supports or medications. Unemployment can lead to depression, or addictions to alcohol, gambling and other substances. Lack of income and extended periods of unemployment can increase stress on a family unit contributing to family breakdowns, violence and mental illnesses. In assessing the health of a community and determining strategies to overcome certain health problems, these factors cannot be overlooked. The CHBs have suggested that lobby initiatives take place to encourage the government to provide employment opportunities and adequate incomes for those unable to find work. Financial resources to support economic development initiatives should also be provided and communities should be encouraged and educated as to how to improve their economic prospects and decrease unemployment rates.

Environmental Concerns:

Another factor contributing either directly or indirectly to the health of a community is the state of the environment in which the residents live. The CHB plans presented a wide variety of concerns from the quality of their drinking water to the affects of second hand smoke to the availability of recycling services and the condition to their highways and roads. Although these factors are outside the responsibility of the Department of Health, they are presented as significant concerns to some of the Community Health Boards. Therefore, government departments and other organizations need to be encouraged to work together to provide a healthy environment for residents of Nova Scotia communities.

ISSUES OF HIGH PRIORITY TO SPECIFIC HEALTH BOARDS

Due to limits on space and time for the completion of this project, it was impossible to cover all of the issues which were of significance to all of the Community Health Boards. The discussion above presents a summary of the most frequently discussed issues in the community health plans. However, some of the individual boards indicated certain issues that were of particular significance to their community that could not be included in a summary of all CHB issues. Please find below an overview of the issues omitted from the above discussion. (Further detail on these issues as well as those discussed above can be obtained from reviewing individual health plans or contacting the author of this report)

Issue	CHBs Affected	Priority	Strategies for Action
Review public consultation process.	Chebucto West	See below	As stated in the issues
Re-examine and revise CHB boundaries in consultation with neighboring health boards	Chebucto West	The Chebucto- West document indicated that this issue was a system wide concern which needed to be addressed before the CHB could adequately plan for the health services of it's community.	Respond to the issue presented
Lack of rehabilitation services	Eastern Kings Annapolis Community Health Board	Included in their high priority or significant concerns list	Expand level of rehab services
Addictions to alcohol, gambling, and prescription and illicit drugs.	Annapolis, Central Kings, Central Inverness, Eastern Kings, Digby, Shelbourne, Western Kings, Clare and Eastern Hants	Central Kings, Central Inverness, Western Kings and Eastern Kings placed the issues on a priority list.	Expand addiction services. Provide preventive educational programs to youths and others.
Prevalence of cancer	Western Kings	High priority list	Develop programs for preventive lifestyle choices and enhance treatment options Enhance palliative care options

Cost of uninsured services	Central Kings, Eastern Kings	Discussed as an issue	Provide financial support for lower income individuals Investigate the possibility of insuring some complimentary services
Develop a step down or convalescent unit for individuals discharged from hospital who cannot be cared for at home	Lunenburg	Priority issue	As indicated in issue
Lack of dental services	Queens	Queens Community Health Board gave assigned the issue a priority one	Increase the age limit or insured dental services beyond the current age of 10 for children Provide assistance to lower income individuals for dental care
NB: Several communities indicated that their community health plans were based on the assumption that existing services would be enhanced or maintained and that there would be no reductions in existing services.			

APPENDIX 1:

Community Health Plans Reviewed:

- Chebucto West Community Health Board
- Cobequid Community Health Board
- Dartmouth Community Health Board
- Eastern Shore-Musquodoboit Community Health Board
- Halifax Peninsula Community Health Board
- South Eastern Community Health Board
- West Hants Community Health Board
- Strait Richmond Community Health Board
- Central Inverness Community Health Board
- North Shore Area Community Health Board
- Pugwash and Area Community Health Board
- Annapolis Community Health Board
- Central Kings Community Health Board
- Clare Community Health Board
- Digby and Area Community Health Board
- Eastern Kings Community Health Board
- Kingston-Greenwood Community Health Board
- Lunenburg Community Health Board
- Queens Community Health Board
- Shelburne Community Health Board
- Western Kings Community Health Board
- Yarmouth County Community Health Board
- East Hants Community Health Board

Appendix 6
Respondent Profile

Data Analysis

Slightly over one thousand workbooks were received. The quantitative data from 923 workbooks was entered into SPSS™ for analysis. Some workbooks were not entered because they appeared to be a draft format and all questions were not the same. Others were not entered due to the date received. Approximately 30% of the workbooks from each county were chosen for analysis of the qualitative data. Percentages are based on the number of respondents to any given item.

Challenges to the Data Analysis

Respondents had the option of choosing yes or no to services in the community, in the district or region or in one place only. Some respondents indicated yes to more than one option, others indicated yes to one and left the other two blank while still other respondents would indicate either yes or no to each option. Although it was assumed that if someone indicated yes to one option and left the other two blank, they were inferring no, there is no way of knowing this for certain. Some respondents indicated a no to some options while leaving others blank. Therefore, if one option was indicated either yes or no and the other two were left blank, they were coded as a "maybe not". This classification is shown separately but can probably be combined with the "no's".

The data for the questions relating to the consultation process is questionable. The boxes did not line up with the questions so it was difficult to tell which question respondents were actually answering. Some respondents drew lines from the question to the answer box but others did not. The data from these workbooks was entered on a "best guess" basis but no guarantees as to its accuracy can be given.

Between 80% and 85% of respondents completed both the white pages and the green pages. However, only about 70% of respondents completed the question on broad determinants of health. Respondents seemed unclear about how they should respond to this question. Generally, there were a number of comments about the service. Many respondents found it unclear and difficult to answer. In particular, a number noted that they felt restricted by the options given that the final option was "one place only in the province". A number noted that they would like the service in more than one area but not necessarily at the district or region level.

Results from Quantitative Data

Table 1 shows the breakdown of respondents by their county of residence. As can be seen, 10% did not indicate where they live. The information from those respondents is included in the analysis but shown separately for any analysis by county. It can be seen that the greatest percentage of respondents live in Annapolis, Cumberland or Kings Counties while the lowest percentage of respondents live in Antigonish, Guysborough, Inverness and Victoria Counties.

Table 1 The number and percentage of respondents by county of residence

County	Number of Respondents	% of Respondents
Annapolis	102	11
Antigonish	12	1
Cape Breton	51	6
Colchester	52	6
Cumberland	114	12
Digby	36	4
Guysborough	11	1
Halifax	85	9
Hants	46	5
Inverness	13	1
Kings	109	12
Lunenburg	45	5
Pictou	27	3
Queens	44	5
Richmond	21	2
Shelburne	25	3
Victoria	9	1
Yarmouth	24	3
Unknown	97	10

The mix of respondents by age does not reflect the age distribution of the province. Table 2 shows that 50% of respondents are between the ages of 41 and 60 while 32% are over the age of 60. Only one percent of respondents is under the age of 21 while based on the 1996 Census, almost 7% of Nova Scotians were between 15 and 19 years of age. As well, the Census shows that 22% of Nova Scotians were 55 or older compared with the 32% of respondents who are over the age of 60. The distribution by age across counties (Table 3) is fairly similar. Nine percent of the respondents in Colchester and 11% of respondents in Pictou were over the age of 80 compared to 2% of total respondents. Cape Breton, Guysborough, Kings and Victoria Counties had a somewhat higher percentage of respondents in the 21 – 40 age group when compared to the total respondents while Antigonish, Digby, Richmond and Shelburne Counties had a somewhat higher percentage in the 41 – 60 age group compared to total respondents

Table 2 The number and percentage of respondents by age

Age	Number of Respondents	% of Respondents
0 – 20	6	1
21 – 40	152	17
41 – 60	437	50
61 – 80	269	30
81+	20	2

Table 3 The percentage of respondents in each age group by county

County	***Age Group*** ***0 – 20*** ***%***	***21 – 40*** ***%***	***41 – 60*** ***%***	***61 – 80*** ***%***	***80+*** ***%***
Annapolis	1	13	54	28	4
Antigonish	0	9	64	27	0
Cape Breton	2	26	44	24	4
Colchester	0	12	48	35	9
Cumberland	3	15	39	42	2
Digby	0	14	61	22	3
Guysborough	0	27	46	27	0
Halifax	0	18	55	27	0
Hants	0	11	59	26	4
Inverness	0	17	58	25	0
Kings	0	27	42	30	1
Lunenburg	2	22	56	20	0
Pictou	0	18	44	26	11
Queens	0	19	55	26	0
Richmond	0	5	60	35	0
Shelburne	0	12	60	28	0
Victoria	0	33	57	11	0
Yarmouth	0	21	33	46	0
Unknown	0	12	46	39	3
Overall	1	17	50	30	2

Over half the respondents work, or have worked, in the health care field (Table 4). There are some notable differences when this is examined by county (Table 5). Over three-quarters of the respondents in Antigonish, Lunenburg and Victoria Counties are, or were, employed in the health care field. Conversely, only one-third of respondents from Cumberland County were in the health care field.

Table 4 The number and percentage of respondents by whether they worked in the health care field

Worked in health care field?	***Number of Respondents***	***% of Respondents***
No	398	45
Yes	483	55

Table 5 The percentage of respondents who worked in the health care field by county

County	Worked in health care field? No %	Yes %
Annapolis	42	58
Antigonish	16	83
Cape Breton	43	57
Colchester	48	52
Cumberland	65	35
Digby	36	64
Guysborough	46	54
Halifax	53	47
Hants	54	46
Inverness	54	46
Kings	39	61
Lunenburg	24	76
Pictou	44	56
Queens	50	50
Richmond	43	57
Shelburne	32	68
Victoria	12	88
Yarmouth	38	62
Unknown	39	61
Overall	45	55

When asked the type of work in the health care field, 59% indicated they were a service provider (Table 6). It should be noted that some respondents indicated more than one area. In those cases, the first one was coded as the response. This could mean that the number of service providers may be slightly higher than indicated. Thirty-five percent of respondents from Hants County indicated they worked as a support person compared to 15% of the total respondents. Eighty-three percent of respondents from Inverness and 82% from Pictou Counties indicated they were service providers compared to 59% of the total respondents, while 44% of respondents from Shelburne indicated they were in administration/planning compared with 26% of total respondents (Table 7).

Table 6 The number and percentage of respondents by the type of work in the health care field

Type of Work	Number of Respondents	% of Respondents
Administration/planning	123	26
Service Provider	283	59
Support Person	72	15

Table 7 The percentage of respondents by type of work in the health care field and county

County	Type of Work Administration/planning %	 Service provider %	 Support person %
Annapolis	36	49	15
Antigonish	38	50	12
Cape Breton	36	52	12
Colchester	26	67	7
Cumberland	19	51	30
Digby	30	70	0
Guysborough	33	67	0
Halifax	24	54	22
Hants	5	60	35
Inverness	0	83	17
Kings	23	56	20
Lunenburg	15	71	15
Pictou	6	82	12
Queens	41	45	14
Richmond	27	64	9
Shelburne	44	56	0
Victoria	14	86	0
Yarmouth	33	67	0
Unknown	24	63	13
Overall	26	59	15

Respondents were asked if they are, or ever have been, a Trustee or Board Member of a health care agency, organization or institution. Sixty-eight percent of respondents indicated they had not (Table 8). Additionally, respondents were asked if they are currently a member of a health advocacy group. Seventy-three percent indicated they are not a member of such a group (Table 8). Similar percentages generally were noted when examining the responses by county although some differences were noted. Compared with 32% of the total respondents, only 17% of respondents from Cumberland County were, or had been, a trustee or board member, while 60% of those respondents from Guysborough were, or had been, a trustee or board member. Similarly, only 8% of respondents from Inverness County and 12% of respondents from Cape Breton and Victoria Counties were members of an advocacy group compared with 27% of the total respondents. Digby and Guysborough Counties, on the other hand, had a higher percentage of respondents who are members of an advocacy group with 47% and 46% respectively (Table 9).

Table 8 The number and percentage of respondent by whether respondents were a trustee or board member of a health care agency, organization or institution and whether respondents were a member of a health advocacy group

Trustee or Board Member	*Number of Respondents*	*% of Respondents*	*Member of health advocacy group*	*Number of Respondents*	*% of Respondents*
No	603	68	No	633	73
Yes	277	32	Yes	232	27

Table 9 The percentage of respondents who are, or had been a trustee or board member or who are a member of an advocacy group, by county

	Trustee?		*Member of advocacy group?*	
County	*No %*	*Yes %*	*No %*	*Yes %*
Annapolis	61	39	66	34
Antigonish	58	42	82	18
Cape Breton	72	28	88	12
Colchester	69	31	85	15
Cumberland	83	17	84	16
Digby	64	36	53	47
Guysborough	40	60	54	46
Halifax	77	23	80	20
Hants	74	26	80	20
Inverness	62	38	92	8
Kings	71	29	72	28
Lunenburg	64	36	66	34
Pictou	70	30	67	33
Queens	64	36	75	25
Richmond	50	50	71	29
Shelburne	64	36	52	48
Victoria	56	44	88	12
Yarmouth	58	42	61	39
Unknown	62	38	61	39
Overall	68	32	73	27

Respondents were asked to indicated the importance of a number of beliefs about health. Most respondents indicated that all the beliefs were important with over 90% indicating that all but two were either quite or most important (Table 10).

Table 10 The degree of importance which respondents gave to beliefs about health, expressed as a percentage of respondents indicating a certain rating (most important to not important)

Belief	**Most Important %**	**Quite Important %**	**Somewhat Important %**	**Not Important %**	**Number**
The Health Goals for Nova Scotia tell us what total health is and how we can achieve it.	54	37	8	1	892
We need to create a system that coordinates different government departments, public groups and societies, as well as businesses, to support health.	65	26	7	2	888
Services that help us improve and maintain good health must be available as close to home as possible.	75	22	3	0	901
Communities must be involved in decisions about services that affect their health.	79	17	4	1	906
Nova Scotians are becoming older, so we must organize services that affect health with that in mind.	63	32	5	1	901
Legislation, policy and standards need to be set by the Nova Scotia Government which support Nova Scotians in maintaining their own health.	55	31	11	3	881
We have already done a lot of good work in Nova Scotia about health. Let's use it.	52	33	12	3	837

Respondents were also asked to respond to a number of questions regarding the discussion guide and workbook and the consultation process. As previously mentioned, the data may not be accurate due to layout problems with the workbooks. Fifty-eight percent of respondents indicated that the discussion guide somewhat provided the background information needed to address the questions in the workbook. Forty-six percent reported that the instructions for completing the workbook were not clear. Forty-nine percent indicated they had attended a public meeting while 45% said they were not aware that public meetings were being held (Table 11).

Table 11 The percentage of respondents indicating a particular response (no, somewhat, yes) to questions about the discussion guide and workbook and the consultation process

	No **%**	**Somewhat** **%**	**Yes** **%**	**Number**
The discussion guide provided necessary background information	18	58	25	812
Information in discussion guide was well-organized	12	40	48	808
Instructions for using discussion guide were clear	19	35	46	819
Instructions for completing the workbook were clear	46	12	42	838
Attended a public meeting	45	6	49	778
Plan to attend a public meeting	23	6	71	273
Meeting was sponsored by Provincial Health Council	9	4	87	420
Meeting sponsored by agency or organization	24	8	67	254
Aware that public meetings were held	45	11	54	295

Appendix 7
Preliminary Report March 2000

Provincial
Health Council

ESSENTIAL HEALTH SERVICES:

A Preliminary Report

Report to the Minister of Health Containing a list of Core Clinical Services Nova Scotians Consider Essential to their Health

March 17, 2000

**Suite 301
1888 Brunswick Street
Halifax, NS
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Core Clinical Services

Identified by Nova Scotians

In July of 1999, the Provincial Health Council received a request from the Premier to enter into a consultation process with Nova Scotians to find out what clinical services they felt were needed at the community, district or region, and provincial levels. This report outlines how the Council approached the task, the methods used to consult with Nova Scotians in a meaningful way and the results of that consultation in relation to clinical services.

Approach of Council

The Council, since its current form came into being, has adopted an approach to all issues related to health for Nova Scotians that focuses on the broad determinants of health and the Nova Scotia Health Goals which have been adopted by the current government. These are described in Appendix A. What this has meant for the current process is that we looked more broadly than "core clinical services" and dealt with "core health services" throughout. Core clinical services becomes a sub-set of core health services in this approach.

We also used this as an opportunity to get in direct contact with Nova Scotians: to put a face to council and to begin a dialog with them in relation to health and health issues.

The Process

The Council began by appointing a Core Services Committee and inviting Menna MacIsaac to sit on that Committee. Ms MacIsaac had already done a great deal of work with the Department of Health on core services in previous years, and the Council wished to benefit from that work and Ms MacIsaac's expertise. Next steps included: Appointment of an Advisory Committee to help shape the questions to put to Nova Scotians in our direct consultation, and to begin the process of identifying the core services needed at the three levels. This committee consists of approximately 50 persons with representation from Community Health Boards; the former Regional Health Boards; the non-designated facilities; related professional organisations including the RNANS and the Medical Society; the Departments of Health, Community Services, Environment, Education and Justice; the Sport and Recreation Commission; several non-governmental organisations (primarily health-related charities); and persons who represented special interests or minority communities which were deemed important.

- Preparation of background information relating to core services identified by the NS Department of Health, other provinces, some jurisdictions in the USA, some in Europe, the World Health Organisation and others. We also prepared some statistical information related to population health for Nova Scotia as a whole and for each county. This material was distributed to the Advisory Committee to be used as a background for their work.

- A two-day meeting of the Advisory Committee to begin the process
- Development and distribution of questionnaires in the form of workbooks. Eleven thousand (11,000) of these were printed: 10,000 in English and 1000 in French and were distributed through a number of avenues including the Community Health Boards and other interested groups in a community. Approximately 1000 of these had been returned by our deadline of March 10th. Nine hundred and eighty (980) were analysed by the consulting evaluation research company.
- Consultation with the public through a series of public meetings. Thirty-two (32) of these were held across the province including 3 in First Nations communities. The format of these meetings was originally planned to be workshop/focus group, but the large numbers at many of the meetings made this impossible except for at 6 meetings. Approximately 1100 persons attended these but there was wide variation in the numbers at any one location. Attendance ranged from 360 (Kentville) to 1 (Spryfield).
- Analysis of the workbooks and the reports from public meetings by a consulting firm specialising in evaluation research. This analysis was both qualitative and quantitative.
- Review of all of the Community Health Plans available to date from the Community Health Boards. Various people told us that each CHB had done an extensive assessment of needs in the communities using a variety of assessment processes and that this would provide very valuable information based on more than just a one-time meeting. The review was done for the purpose of identifying the core services noted in the plans. It must be noted that the services taken from the plans were those that the community planned to work on over the coming year(s), and was not an exhaustive list of core services needed on an on-going basis (only on those that were considered deficient or lacking and needed work).

Tabulation of Results

We now had five sources of input on core health services:

- Results from the workbooks
- Results from the public meetings
- Core services derived from the Community Health Plans
- Advice from the Advisory Committee
- Core services identified by the various groups in the Department of Health

These were laid out in a spread sheet format using the original lists from the Department of Health as a beginning template and adding any that were not mentioned by the Department but were noted in the other input sources.

For the workbooks we had input for each of the levels of community, region/district and province. This was also true for the Department of Health information and for the Advisory Committee input. For the input from the public meetings, we assumed that the services noted were intended to be available in the community. We considered this input for the community level only. For the Community Health Plans we knew that the services outlined were to be for the community level since that fit with the role of the Community Health Boards (their job is to be responsible for primary health in the Community).

First, we determined that each of the sources of input would carry equal weight. Although the numbers of people involved would not be equal there were several factors that helped us to determine this:

- The total number of people who completed the workbooks was approximately equal to the total number of people who attended the public meetings so these could be considered more or less equal overall.
- The advisory committee had considerable expertise and background information to inform their decisions. They also had the benefit of a two-day process with skilled facilitation to bring out their thinking. Their input would have significant weight: deemed equal to that of the two noted above.
- The Community Health Boards developed their plans through a carefully conceived process that was designed to bring out the needs of the communities over time. This would give the results in the form of Community Health Plans significant weight: deemed equal to that given the first two inputs.
- The staff of the Department of Health (who are also people of Nova Scotia) have done considerable study of information from providers and other sources, and of data related to utilisation patterns. Their input on clinical services they have identified should then also carry equal weight to that given the first two.

Next formulas were applied to the numbers to get an overall result for each of the clinical services mentioned, in each category of "community", "region/district" and "one place only". The formulas resulted in a number that could not equal more than 100 and that would reflect the weights mentioned above. In determining where to put the X on the results page, we put an X wherever the service had more the number 20 so that a strong recommendation on the part of any one input source would carry that item.

The results are on the following table. The background numbers that created these results are attached in Appendix B.

Service		Community	Region	One Place
SURGERY				
	Cardiac			X
	General	X	X	X
	Urology (incl. Lithotripsy)		X	X
	Neurological			X
	Reconstructive & plastic		X	X
	Cardiovascular			X
	Orthopedic		X	X
	Oral & maxillofacial		X	X
	Organ transplantation and follow-up			X
	Vascular & thoracic		X	X
ANAESTHESIA			X	X
MEDICINE				
	Cardiology		X	X
	General	X	X	X
	Endocrinology (excluding Diabetes care)		X	X
	Diabetes Care	X	X	X
	Oncology & radiation		X	X
	Nephrology		X	X
	Ophthalmology		X	X
	Neurology		X	X
	Pain management	X	X	X
	Hematology		X	X
	Gastroenterology		X	X
	Respirology		X	X
	Rheumatology		X	X
	Dermatology		X	X
	Immunology		X	X
	Otolaryngology	X	X	X

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		Community	Region	One Place
	Family	X	X	X
	Infectious Diseases		X	X
OBSTETRICS				
	Routine pre & postnatal care	X	X	X
	High & low risk		X	X
	Breast feeding support	X		
GYNAECOLOGY				
	General		X	X
	Oncology			X
PAEDIATRICS				
	General	X*	X*	X*
	Growth & development			
	Clinical immunology & allergy			
	Oncology			X
INTENSIVE CARE				
	Medical		X	X
	Surgical		X	X
	Critical		X	X
	Cardiac		X	X
	Burns		X	X
	Neonatal		X	X
	Paediatric		X	X
DIAGNOSTICS				
	Radiology		X	X
	Mammography screening	X	X	X
	Phlebotomy services	X	X	X
	Imaging		X	X

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		Community	Regiona	One Place
	Laboratory medicine		X	X
	Medical microbiology		X	X
	Occupational therapy	X	X	X
	Physiotherapy	X	X	X
EMERGENCY SERVICES				
	Level 1	X		
	Level 2	X	X	
	Level 3		X	X
Pathology			X	X
Rehabilitation		X	X	X
Prosthetics			X	X
Palliative care		X	X	X
Dentistry		X	X	
Restorative care			X	
Geriatrics		X	X	X
Bone marrow transplants				X
Genetics				X
Dermatology/laser		X	X	X
Sleep disorders				X
Speech language pathology			X	X
Vision Care		X	X	
ADDICTION SERVICES				
	General	X		
Treatment	Assessment	X	X	
	Intervention	X	X	

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		Community	Region	One Place
	Detoxification-day program	X	X	
	Detoxification - Inpatient		X	
	therapy/counseling (treatment education)	X	X	
	Structured treatment - modular program	X		
Targeted	Adolescent treatment	X	X	X
	Women's drug dependency services	X	X	X
	Driving while impaired-second offender's program	X	X	X
Structured	Residential & non-residential rehabilitation program CORE		X	X
	Long-term sheltered environment option		X	
	Halfway sheltered environment option		X	

MENTAL HEALTH

	General	X	X	X
	Community mental health promotion & education	X	X	
	Community mental health prevention & early intervention			
Adult	Outpatient assessment and treatment	X		
	Day hospital & day treatment		X	
	Intensive community-based acute treatment services	X		
	Acute inpatient services - short stay unit		X	X
	Specialized inpatient services			X
	Consultation/liaison services		X	X
Specialty	In-hospital treatment or outpatient clinics for special diagnostic groups		X	X
	Forensic service			X
	Psychogeriatrics		X	X
Community Support	Individualized case management	X		
	Support consumers with serious & long-term mental health difficulties	X		
	Consumer empowerment	X		

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		Community	Region	One Place
	Clubhouse and consumer initiated services	X		
Child & Youth	Inpatient/outpatient outreach	X		
	Early identification & intervention services	X		
	Residential care and treatment services	X	X	

PUBLIC HEALTH

	General	X	X	X
Communicable Disease	Non-vaccine preventable diseases	X	X	X
	Vaccine preventable diseases	X		
	Outbreak investigation & management	X		
Non-Communicable Disease	Healthy beginnings program	X		
	Early childhood program	X		
	Modifiable risk factor reduction	X		
Enhancement	School-aged children & youth	X		
	Community health promotion fund	X		
	Community social supports	X		

LONG TERM CARE

	General	X	X	
	Assessment	X	X	X
	Placement	X		
Service Delivery	Case Management	X		
	Health enhancing services	X		
	Diagnostic & treatment services		X	
	Continuing care services		X	
	Therapeutic, diagnostic and support services		X	
	Supplementary services		X	X

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HOME CARE

		Community	Region	One Place
	General	X	X	X
	Assessment	X		
	Case Management	X		
	Referral	X		
Service Delivery	Nursing care	X		
	Personal care	X		
	Home support	X		
	Oxygen therapy	X		

Other Findings Related to Core Clinical Services

We found in reviewing all of the input from a variety of sources that there is a clear difference between the way in which "average" Nova Scotians (as represented by those who participated in the public meetings, prepared the Community Health Plans, and submitted workbooks, as well as some of the results from the Advisory Committee) look at health services; and the way in which providers and policy developers (as represented by some of the Advisory Committee input and the Department of Health input). The first group – "average Nova Scotians" – spoke of services for people in a holistic way: noting statements like "we want services for our seniors" or "we need health centres for our youth", without breaking that down into the clinical pieces that make up those services for a person. The second group tended to think of clinical services as those things that providers do i.e. urology, psychogeriatrics, assessment and treatment of addictions for youth. We felt this paradigm difference to be important. By taking a community perspective, focussed on the people of the community as a starting point, we may find that our clinical services can be organised differently with processes that follow a person through the range (continuum) of particular clinical services they need for their health maintenance. Thus we see a strong emphasis on information systems that would help people understand the services available to them, and would help cross the lines of clinical components by providing patient information across the system, not just in each component clinical piece. We also saw a lot of emphasis on integration and co-ordination of services, especially for those who have difficulty understanding how all the clinical pieces fit together (brain injured, elderly, those with mental illnesses).

Following is a list of the items we felt were relevant to clinical services and their delivery, although they were not clinical services themselves. There were a number of "core services" or issues that emerged frequently in many of the sources.

- The need for care and service delivery models which include:
  - ➢ Community Health Centres
  - ➢ Youth Health Centres
  - ➢ Convalescent care and restorative care given in the community
  - ➢ Specialist and outpatient/screening clinics in the community
  - ➢ Respite care in the community

- The need for information, on two levels:
  - ➢ for citizens to access easily, regarding healthy living, health services available, and access,
  - ➢ a health system information network to support clinical decision-making, continuity of care and quality service delivery

- The need for coordination and integration of services provided, across providers and departments. This was sometimes put forward as "singly-entry" or "case management" for individuals, but also applied more broadly to whole programs and initiatives, especially as they cross government department lines.

- Transportation to primary health services in communities and to tertiary level services in other centres.

- The need to have health professionals like Nurse Practitioners and others who are not physicians available in the community to take care of health needs and concerns that don't need a physician's attention.
- Services for special groups including persons with environmental illness and persons who have suffered brain injuries.
- The need to make sure we have a healthy physical environment in which to learn, work and live. This includes clean water and air and uncontaminated foods.
- Support for the many volunteers that provide much of the care in communities.
- The need for ongoing research (including evaluation), drug trials and attention to epidemiology (evidence-based decision making).
- Education for health service providers to foster the ability to be culturally and situationally appropriate.
- The need for supports for families (parenting skills, etc) through such agencies as Family Resource Centres.

Next Steps

The Council had determined to look at this matter of core clinical services within the broader context of health services. This reflects our concern for looking at health for the people of Nova Scotia in a broad way. Clinical health service provision makes up one component of those elements that affect people's health. Our full report on core services, which will be available by the end of June 2000, will reflect health services more fully. For purposes of this report, we have pulled out the information relevant to the provision of core clinical services. We will later incorporate this component into a fuller report on the core health services that Nova Scotians identified through all of the sources noted for core clinical services.

Appendix A

The Determinants of health include:

Income and Social Status
Greater income & higher social status generally equals better health.

Social Support Networks
If you have the support of family and friends you are generally healthier.

Education
Higher educational levels lead to better health.

Employment and Working Conditions
The more control you have over working conditions and employment, the healthier you will be.

Physical Environment
Exposure to harmful physical, chemical and biological agents can damage your health.

Social Environment
Social support and isolation, emotional deprivation, stress, learned coping skills all have an impact on your health status.

Biology and Genetic Endowment
Your family history of health and illness can affect your own health.

Personal Health Practices and Coping Skills
The choices you make about things like smoking, sexual practices, health care practices and diet all affect your health status.

Healthy Child Development
The best way to ensure that a group of people is healthy is to make sure that its children have a good start in life. A well nourished, educated and challenged childhood will lead to a healthy adult.

Health Services Available
The health services available play a small part in your health status. The health service that most affects the health of a group of people is getting rid of childhood diseases.

Gender
Women still live longer than men.

Culture
Culture plays a large part in the way we relate to health, illness, the health care system, our lifestyle choices and many other areas of our life.

Core Clinical Services Report; Provincial Health Council; March, 2000

NOVA SCOTIA'S HEALTH GOALS

Health is the capacity to function optimally and to achieve well-being.

We believe that all nova Scotians can achieve health.

We believe that the health of individuals and communities has many aspects, including emotional, physical, social, and spiritual well-being.

We see the health of our people as a resource for the present and the future. Each of us has a role to play to protect and develop that resource. Education, particularly of our children and youth, is very important.

We believe our health care system must remain publicly administered, comprehensive, universal, portable, and accessible to all Nova Scotians. Public administration must include public participation and accountability.

Together, as individuals and members of groups and communities, and with all government departments, we commit ourselves to these health goals.

Our Goals:

Health Promotion: Promote and improve the health of all Nova Scotians.

While continuing to provide quality health care, we will shift our emphasis to the promotion of health and the prevention of illness, disability and premature death.

Healthy Environment: Make Nova Scotia a safe and healthy place to live.

To be healthy, we need clean air, water and soil, as well as safe places to live, work and play. We will restore, protect and develop our environments to support health.

Healthy Living: Support the efforts of individuals, families and communities to lead healthy lives.

We will support each other in our efforts to understand the factors that affect our health and take responsibility for those things we can control.

Management: Ensure that the resources needed to support health are managed wisely and fairly.

Our taxes pay for the people, programs, equipment and facilities that support health. These and other resources will be used in ways that are open, effective, efficient and accountable.

Participation: Involve Nova Scotians in decisions affecting health.

Opportunities and support must be provided for all of us to participate in making decisions about our health and the health care system. All decision makers are accountable to the public for their actions.

Social Justice: Ensure that all Nova Scotians have the opportunity to achieve health.

Poverty, unemployment, racism, illiteracy, violence, rural isolation and other issues, make it more difficult for some people to be as healthy as others. The policies we put in place must address these factors that affect our health.

Core Clinical Services Report; Provincial Health Council; March, 2000

Appendix B

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		Comm	Reg	Prov	Comm	Comm	Comm	Reg	Prov	Comm	Reg	Prov
		%	%	%								
Surgery	Cardiac	9	50	49					1			1
Surgery	General	47	66	5	1			1	1	1	1	1
Surgery	Urology (incl. lithotripsy)										1	1
Surgery	Neuro	11	44	53					1			1
Surgery	Reconstructive & plastic	8	46	57							1	1
Surgery	Cardiovascular											1
Surgery	Orthopedic	18	75	22				1			1	1
Surgery	Oral & maxillofacial							1	1		1	1
Surgery	Organ transplantation and follow-up											1
Surgery	Vascular & thoracic	11	61	40				1	1		1	1
Anaesthesia		40	69	7				1	1		1	1
Medicine	Cardiology	41	68	12			1	1	1	1	1	1
Medicine	General	87	33	2		1					1	1
Medicine	Endocrinology	44	67	12								1
Medicine	Oncology & radiation										1	1
Medicine	Nephrology	23	71	20				1				1
Medicine	Ophthalmology	42	68	10				1	1		1	1
Medicine	Neurology	24	68	22				1			1	1
Medicine	Pain management									1	1	1
Medicine	Haematology	61	52	8				1	1			1
Medicine	Gastroenterology	30	74	12				1			1	1
Medicine	Respirology	40	70	11				1			1	1
Medicine	Rheumatology	38	68	13								1
Medicine	Dermatology	26	73	17				1			1	1
Medicine	Immunology	55	49	13				1	1			1
Medicine	Otolaryngology	31	75	11			1	1	1		1	1
Medicine	Family	94	30	1	14	1				1	1	1
Medicine	Infectious Diseases	49	59	14				1	1			1
Obstetrics	Routine pre & postnatal care	90	27	1	3			1	1	1	1	1
Obstetrics	High & low risk							1	1		1	1

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		**Comm**	**Reg**	**Prov**	**Comm**	**Comm**	**Comm**	**Reg**	**Prov**	**Comm**	**Reg**	**Prov**
Gynaecology	General	48	68	7				1			1	1
Gynaecology	Oncology											1
Pediatrics	General	54	59	11	2			1	1	1	1	1
Pediatrics	Growth & development											1
Pediatrics	Clinical immunology & allergy											1
Pediatrics	Oncology	23	57	40								1
Intensive Care	Medical							1			1	1
Intensive Care	Surgical										1	1
Intensive Care	Critical										1	1
Intensive Care	Cardiac										1	1
Intensive Care	Burns	19	62	33					1			1
Intensive Care	Neonatal								1		1	1
Intensive Care	Paediatric										1	1
Diagnostics	Radiology	76	48	6	1						1	1
Diagnostics	Mammography screening									1	1	1
Diagnostics	Phlebotomy services				2					1	1	1
Diagnostics	Imaging	73	46	3				1	1			1
Diagnostics	Laboratory medicine	73	46	3				1	1		1	1
Diagnostics	Medical microbiology										1	1
Occupational therapy		66	49	2	6		1	1	1	1	1	1
Physiotherapy		81	38	1	6	1	1	1	1	1	1	1
Emergency services	Level 1	94	23	1	14	1				1		
Emergency services	Level 2				2	1		1			1	
Emergency services	Level 3					1					1	1

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		Comm	Reg	Prov	Comm	Comm	Comm	Reg	Prov	Comm	Reg	Prov
Pathology								1	1		1	1
Rehabilitation		47	64	18	3						1	1
Prosthetics												1
Palliative care		87	31	2	7	1	1	1	1	1	1	1
Dentistry		87	35	3	5					1	1	
Restorative care											1	1
Geriatrics								1	1		1	1
Bone marrow transplants												1
Genetics												1
Dermatology/laser												1
Sleep disorders												1
Speech language pathology		54	59	3				1				1
Drug Dependency - Prevention & community education	Health promotion	72	47	3	13	1				1		
Drug Dependency - Prevention & community education	Education				2					1		
Drug Dependency - Prevention & community education	Training of allied professionals											
Drug Dependency - Prevention & community education	community development				1					1		

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		Comm	Reg	Prov	Comm	Comm	Comm	Reg	Prov	Comm	Reg	Prov
Drug Dependency - Community-based treatment services	Assessment									1		
Drug Dependency - Community-based treatment services	Intervention									1		
Drug Dependency - Community-based treatment services	Detoxification-day program	29	74	11				1		1		
Drug Dependency - Community-based treatment services	therapy/counseling (treatment education)	63	53	3						1		
Drug Dependency - Targeted dependency services	Adolescent treatment	69	48	4	4					1	1	1
Drug Dependency - Targeted dependency services	Women's drug dependency services	67	49	3						1	1	1
Drug Dependency - Targeted dependency services	Driving while impaired-second offender's program									1	1	1
Drug Dependency - Structured treatment	Residential & non-residential rehabilitation program CORE	53	61	5							1	
Drug Dependency - Structured treatment	Long-term sheltered environment option										1	
Drug Dependency - Structured treatment	Halfway sheltered environment option										1	

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		**Comm**	**Reg**	**Prov**	**Comm**	**Comm**	**Comm**	**Reg**	**Prov**	**Comm**	**Reg**	**Prov**
Mental health promotion, advocacy, education & prevention program	Community mental health promotion & education	76	44	3	11	1		1	1	1		
Mental health promotion, advocacy, education & prevention program	Community mental health prevention & early intervention						1	1		1		
Mental Health - Adult outpatient and outreach mental health program	Outpatient assessment and treatment				1					1		
Mental Health - Adult outpatient and outreach mental health program	Day hospital & day treatment										1	
Mental Health - Adult outpatient and outreach mental health program	Intensive community-based acute treatment services				1					1		
Mental Health - Adult inpatient program	Acute inpatient services - short stay unit	53	61	5							1	
Mental Health - Adult inpatient program	Specialized inpatient services										1	1
Mental Health - Adult inpatient program	Consultation/liaison services										1	1

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		Comm	Reg	Prov	Comm	Comm	Comm	Reg	Prov	Comm	Reg	Prov
		%	%	%								
Mental Health - Specialty programs	In-hosital treatment or outpatient clinics for special diagnostic groups									1	1	1
Mental Health - Specialty programs	Forensic service	13	33	46								1
Mental Health - Specialty programs	Psychogeriatrics										1	1
Mental Health - Community mental health supports for adults	Individualized case management									1		
Mental Health - Community mental health supports for adults	Support consumers with serious & long-term mental health difficulties									1		
Mental Health - Community mental health supports for adults	Consumer empowerment									1		
Mental Health - Community mental health supports for adults	Clubhouse and consumer initiated services				1					1		
Mental Health - Child & youth mental health program	Inpatient/outpatient outreach	72	45	4	1					1		
Mental Health - Child & youth mental health program	Early identification & intervention services				8					1		
Mental Health - Child & youth mental health	Residential care and treatment services									1	1	

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		**Comm**	**Reg**	**Prov**	**Comm**	**Comm**	**Comm**	**Reg**	**Prov**	**Comm**	**Reg**	**Prov**
Public Health - Communicable disease prevention & control	Non-vaccine preventable diseases	82	35	2	1		1	1	1	1		
Public Health - Communicable disease prevention & control	Vaccine preventable diseases									1		
Public Health - Communicable disease prevention & control	Outbreak investigation & management									1		
Public Health - Non-communicable disease prevention	Healthy beginnings program	75	46	2						1		
Public Health - Non-communicable disease prevention	Early childhood program									1		
Public Health - Non-communicable disease prevention	Modifiable risk factor reduction									1		
Public health enhancement	School-aged children & youth									1		
Public health enhancement	Community health promotion fund									1		
Public health enhancement	Community social supports									1		
Long-term Care	Assessment				10	1	1	1		1	1	1
Long-term Care	Placement									1		
Long-term Care - Service delivery with referrals as appropriate	Case Management									1		

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		Comm	Reg	Prov	Comm	Comm	Comm	Reg	Prov	Comm	Reg	Prov
Long-term Care - Service delivery with referrals as appropriate	Health enhancing services									1		
Long-term Care - Service delivery with referrals as appropriate	Diagnostic & treatment services										1	
Long-term Care - Service delivery with referrals as appropriate	Continuing care services										1	
Long-term Care - Service delivery with referrals as appropriate	Therapeutic, diagnostic and support services										1	
Long-term Care - Service delivery with referrals as appropriate	Supplementary services										1	1
Home Care	Assessment	97	22	1	17	1	1	1	1	1		
Home Care	Case Management									1		
Home Care	Referral									1		
Home Care - Service Delivery	Nursing care									1		
Home Care - Service Delivery	Personal care									1		
Home Care - Service Delivery	Home support									1		
Home Care - Service Delivery	Oxygen therapy									1		

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		**Comm**	**Reg**	**Prov**	**Comm**	**Comm**	**Comm**	**Reg**	**Prov**	**Comm**	**Reg**	**Prov**
Information - about healthy living,health services and access		70	55	20	20		1	1	1			
Transportation		86	33	2	16	1						
Convalescent Care / Restorative Care					5			1				
Health Promotion / Education / Illness prevention		74	43	19	18	1						
Nutrition education and counselling		89	28	1	8	1	1					
Community Health Centre, (includes community acute care/"hospital"					10	1		1	1			
Alternate health care providers and services		52	54	11	4							
Integration and coordination of health services provided		59	56	12	11	1	1	1	1			
Review of insured services					14							
Services for seniors					4							
Civic numbering completed and accurate maps available					8							
Specialist and Outpatient/screening Clinics in the community					2	1						

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		**Comm**	**Reg**	**Prov**	**Comm**	**Comm**	**Comm**	**Reg**	**Prov**	**Comm**	**Reg**	**Prov**
Satellite primary care for isolated rural areas					4							
Nurse Practitioners					2	1						
Services for persons with Environmental Illness					3	1						
Youth health centres					4							
Services for the disabled					5							
Respite care		91	27	1	10	1						
Healthy Environment					4		1	1	1			
Dental Care					5							
Support for volunteers					1	1	1					
Primary care					1							
Workplace health & safety					2							
Visual Care							1	1				
Medications												
Breast feeding support		86	29	1								
Parenting programs		87	30	1	11		1					
Sexual and reproductive health		77	38	4								
Family planning		79	37	2								
Suicide prevention		78	41	2								
Chronic disease education		69	48	4								
Safety		82	37	4								

Core Clinical Services Report; Provincial Health Council; March, 2000

		Workbook			CHB Plans	Pub Meet	Advisory Committee			Department of Health		
Service		**Comm**	**Reg**	**Prov**	**Comm**	**Comm**	**Comm**	**Reg**	**Prov**	**Comm**	**Reg**	**Prov**
Mental health/Mental illness services	Self-help	85	31	2								
Mental health/Mental illness services	Early intervention	85	33	2								
Primary obstetrical care		72	47	2								
Primary geriatric services		83	38	2								
Tertiary/speciality geriatrics		76	47	3								
Tertiary/specialty obstetrics		69	51	3								
Services for the brain injured						1						
Research / Drug Trials/Epidemiology								1	1			
Specialized Psychiatry								1	1			
Plastic surgery								1				
Urology								1				
Rheumatology								1				
ENT								1				
Oncology								1	1			
Disaster Readiness							1	1	1			
Transplantation									1			
Education for Health Providers							1	1	1			
Prosthetics/Orthotics								1				
Pain Management								1	1			

Core Clinical Services Report; Provincial Health Council; March, 2000